POPCOM
Empowering Filipino Families

INFORMATION AND SERVICE DELIVERY NETWORK (ISDN) FOR ADOLESCENT HEALTH AND DEVELOPMENT (AHD)

ISDN4AHD

Adolescent Health and Development
Learning Tool No. 18-03

Guidebook

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INFORMATION AND SERVICE DELIVERY NETWORK (ISDN) FOR ADOLESCENT HEALTH AND DEVELOPMENT (AHD)

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Guidebook

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Welfareville Compound, Acacia Lane, Mandaluyong City

(632) 531-7164 (632) 531-6805
(632) 533-5122
mainmail@popcom.gov.ph
www.popcom.gov.ph
fb.com/commissiononpopulationanddevelopment

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FOREWORD

Adolescents and youth remain critical and vital components of our country's current and future development. However, Filipino adolescents continue to face threats and challenges that can undermine their capacity to achieve their potentials and aspirations. One of these important challenges is their lack of access to appropriate information and services related to their sexual health and development may it be in school or other institutions and at home. Some institutions including the government and civil society organizations are providing different interventions on Adolescent Health and Development (AHD). However, these interventions are limited in terms of coverage, resources, and contents. Furthermore, these are not effectively integrated and harmonized because they are being pursued independently.

Addressing the multifaceted phenomenon of the various issues besetting the adolescents particularly teenage pregnancy requires multidimensional interventions. As such, there is a need to harmonize existing information and services on adolescent health and youth development particularly at the local level to generate greater efficiency and effectiveness of key strategies and interventions including resource allocation.

Within this context, POPCOM has promoted the establishment of the **Information and Service Delivery Network for Adolescent Health and Development (ISDN4AHD)** to harmonize existing information and service interventions at the local level. The ISDN is a constellation or network of information and services programs related to adolescent health and development being provided by different organizations including government agencies and civil society organizations operating within a given area. At its core is the Teen Center, a one-stop-shop facility that aims to provide comprehensive information and services for adolescents.

It is our hope that this knowledge product can help interested institutions working on Adolescent Health and Development especially at the local level in improving young people's access to appropriate information and services. It is a useful reference guide to LGUs, schools, and other agencies in setting-up sustainable mechanisms to ensure access of information and services to young people.

We encourage all relevant organizations and adolescent health workers to use and promote this material to continuously enable and empower Filipino adolescents towards the realization of their life goals and aspirations.

DR. JUAN ANTONIO A. PEREZ III, MPH
Executive Director

SECTION 1

THE FILIPINO ADOLESCENTS TODAY

SECTION 1
THE FILIPINO ADOLESCENTS TODAY

Countries recognize that youth involvement is imperative in sustainable development initiatives. As such, more than one third of the Sustainable Development Goals (SDGs) targets has reference to the empowerment, participation and well-being of young people (United Nations Development Programme, 2017). As such, with their critical role in sustainable development, there is a need to address the different risks and threats they face today. There is a need to create and sustain an enabling environment where young people are capacitated and empowered to achieve their potentials. Such enabling environment can be facilitated by efficient and comprehensive programs including effective structures and institutional mechanisms that improve access of young people to needed information, competency, and services.

Journeying through a Difficult Road. Adolescents tread a critical journey from childhood to adulthood. Their journey covers the period after childhood and before adulthood along the age range of 10-19 years (WHO, 2010). It starts with bodily changes at puberty, a stage in development characterized by intense physical, emotional, and social behavior changes which ends at acquisition of social roles and responsibilities toward adulthood.

As adolescents grow and mature, they also become vulnerable to human rights violations, particularly in the domains of sexuality and reproductive health; gainful livelihood and employment; unwanted sex, pregnancy or marriage; sexually transmitted infections (STI), including HIV/AIDS; and even death or disability due to early childbirth (United Nations Population Fund (UNFPA) 2014). With the onset of puberty at an earlier period than usual, the current generation of adolescents begin sexual activity sooner rather than later. This early onset of puberty observed among today's adolescents exposes them to the risks of reproductive health problems, foremost among which is teenage pregnancy. The National Youth Assessment Study of the National Youth Commission (NYC) done in 2015 shows that 24.6 % of Filipino youth indicated that they already have children, 13.8% were married, 31% had engaged in sex and 48% are not aware of HIV/AIDS that anyone can acquire by their risky sexual behavior (Dar, 2016).

The landscape where adolescents are nurtured is also changing fast. The traditional family and community influences are slowly being replaced by social media. Not only has the social media positively transformed the way youth groups interact and participate in societal affairs, it has also negatively impacted the adolescents' physical activity and opened up avenues for online abuses between them. Experts assert that despite the technological advances in communication, many adolescents are ill-informed (Lagman, 2007).

Talking to parents or other family members about matters that bear on their sexual and reproductive health is an important skill for adolescents to acquire self-protection. However, in most Filipino homes, this mode of communication rarely takes place. Confounding this problem are some parents who often lack correct information about adolescent sexuality themselves while others are too embarrassed to talk about sexuality and reproductive health with their adolescent children.

While most of today's youth are hooked on the Internet through their wireless and mobile gadgets, more than two in five Filipino youth reported having no source of information about sex and reproduction at all (Young Adult Fertility and Sexuality Study (YAFS)), 2013. As such, peers have become the main source of information about these topics.

On the global scale, millions of adolescents lack access to sexual and reproductive health information and services, yet, these facets are at the core of their maturity and ability to realize their sexuality and reproductive health. Although the Philippines has sexuality education policy enshrined in Republic Act No. 10354 (Responsible Parenthood and Reproductive Health (RPRH) Law of 2012), the mandate to integrate Comprehensive Sexuality Education (CSE) in formal and informal curriculum is to be fully implemented.

Indeed today's adolescents are besieged with vulnerabilities and uncertainties. On one hand, it is during this period that adolescents are most likely to engage in risky sexual behavior which leads to teen pregnancy, but, on the other hand, it is also during this period of their growth and development when they naturally progress towards psychological and social maturity, develop personal identity and concretize belief systems (Lagman, 2007). It is also a time when the young person is most receptive to new ideas and values. Hence, it is essential for adults in the community to ensure that the period of youth and adolescence must be that when young individuals are nurtured in an atmosphere that encourages and enables them to seek the right path towards decision-making behavior done at the right time and sourced from the right individuals. This implies that society ought to guide youth and adolescents in their transition from dependence to independence so that the choices make are protected for them to fully contribute to the economic and sociopolitical activities way into adulthood (Lagman, 2007).

Fragmented Implementation of Adolescent Health and Development Programs

The various issues including the increasing incidence of teenage pregnancy being faced by adolescents today are caused by complex and interrelated factors. One of these important factors is their lack of access to appropriate and comprehensive information and services related to their sexual health and development.

While there are many communication and education programs being implemented by national government agencies, civil society organizations, and private sectors, these interventions are limited in terms of coverage, resources, and contents. More importantly, these are not effectively implemented as one integrated, harmonized, and comprehensive intervention since they are implemented in fragmented way.

Given this, addressing the multifaceted phenomenon of adolescent issues particularly teenage pregnancy requires multidimensional and multisectoral interventions. There is a need to harmonize existing information and services on adolescent health and development particularly at the local level to generate greater efficiency and effectiveness of key strategies and interventions including resource allocation.

Within this context, the **Information and Service Delivery Network (ISDN) for Adolescent Health and Development** is being promoted as a mechanism to consolidate and integrate existing information and service interventions in a locality into one single functional network. The ISDN is a constellation or network of information and services programs related to Adolescent Health and Development being provided by different organizations including government agencies and civil society organizations operating within a given area. It includes information interventions with the objectives of improving the knowledge, awareness, and behavior of adolescents through various communication strategies including symposium, training, IEC materials, and social mobilization. Services for adolescent health include those that ensure the health and wellness, social, psychological, and total well-being of young people.

An important support and convergent intervention in the operationalization of the ISDN is the **AHD Centers or Teen Centers**. Teen Centers are one-stop-shop facility where adolescents can easily access a wide range of information and services to ensure their health and wellbeing.

ABOUT THIS GUIDEBOOK

This Guidebook provides information on setting-up and sustaining an Information and Service Delivery Network (ISDN) and its key component - the Teen Centers. It is intended for the use of health and population workers, policymakers, program and project managers working on AHD, and stakeholders interested in setting-up the ISDN and the Teen Center for Adolescent Health and Development. The processes and procedures provided in this Guidebook were generated from the following sources:

1. documentation of good practices at the local government units (LGUs) in the country and at the international level (through review of secondary sources);
2. inputs from consultations, field visits, focus group discussions, and key informant interviews with key stakeholders; and
3. review of researches, project documentations, and other literature on setting-up service delivery network and teen centers.

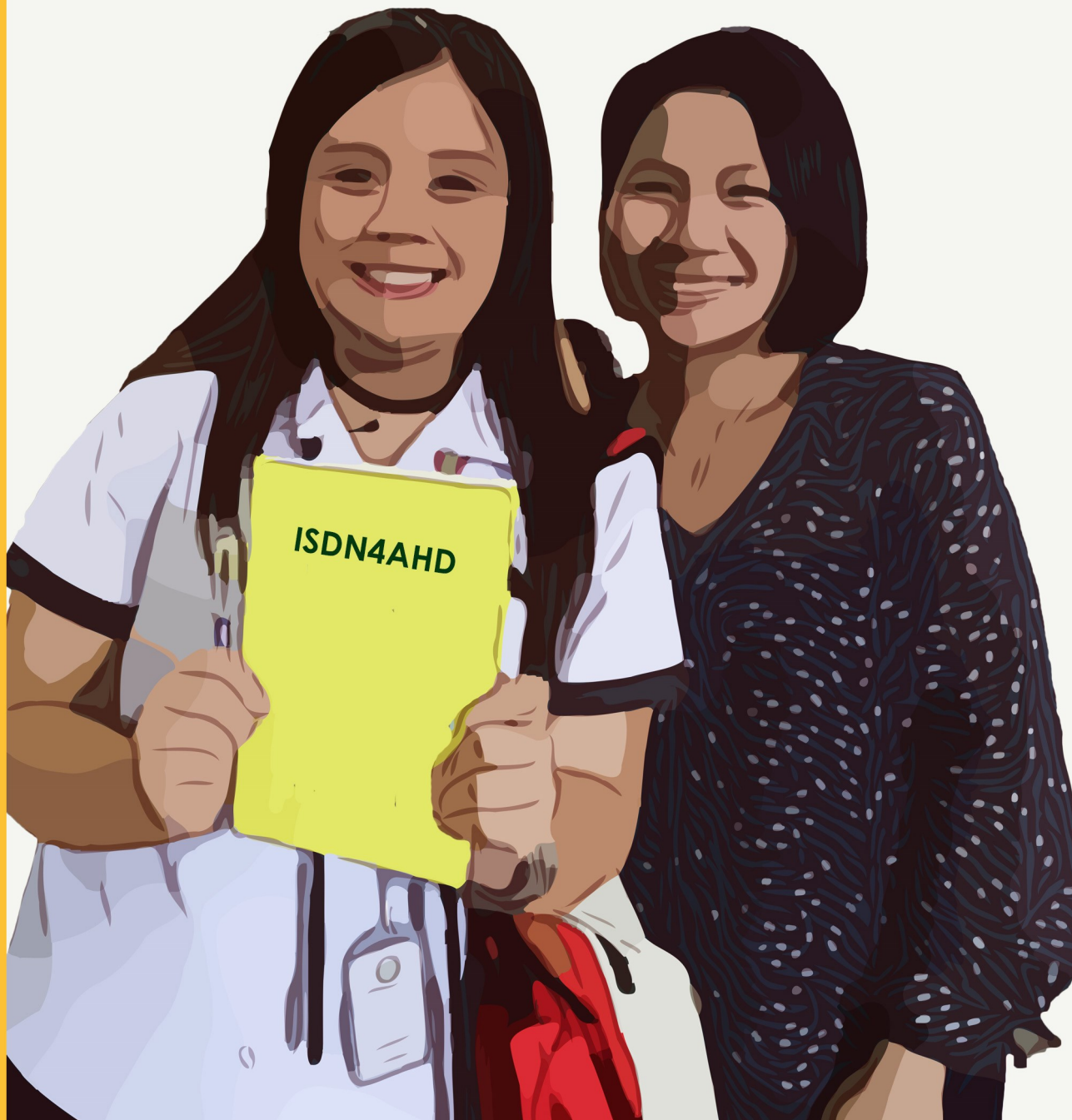
As such, this Guidebook is a compilation of good practices, strategies, and activities that may be adopted in full or in part depending on the context, need, and available resources of the users.

This Guide is divided into the following major parts:

Sections	Title	Description
1	Introduction	This section discusses the context and background of the ISDN and Teen Centers.
2	Defining ISDN for AHD	This section describes the definition of ISDN, its purpose, composition, roles and functions, and major components and processes for its establishment.
3	Understanding the Needs and Issues of Adolescents in the Community	This section provides information on the first step of the process which is to identify and understand the needs and issues of the adolescents within the community. This will serve as the basis for appropriate interventions to be undertaken through the ISDN.
4	Mapping Available Interventions and Services for Adolescents	This section instructs the processes in mapping the available interventions and services for young people within the community. From this map, the critical members of the ISDN will be identified.
5	Setting-up and Mobilizing the Coordinative Structure and Referral System for the ISDN	This section instructs the steps in formally organizing the ISDN. It includes the development of a comprehensive AHD Action Plan and referral system including collaborating mechanism among key members of the ISDN. It also discusses the means by which the ISDN can be formally organized and operationalized.
6	Establishing the Teen Center	This section provides guidelines in the establishment of Teen Centers as a convergence facility of all members of the ISDN.
7	Promoting the ISDN and Teen Center	This section provides some strategies and activities that can be done to promote the ISDN and Teen Centers among the target clients and other stakeholders.
8	Monitoring and Evaluating the ISDN	This section recommends a monitoring and evaluation mechanism to assess and evaluate the ISDN and Teen Center interventions.

SECTION 2

DEFINING ISDN FOR AHD

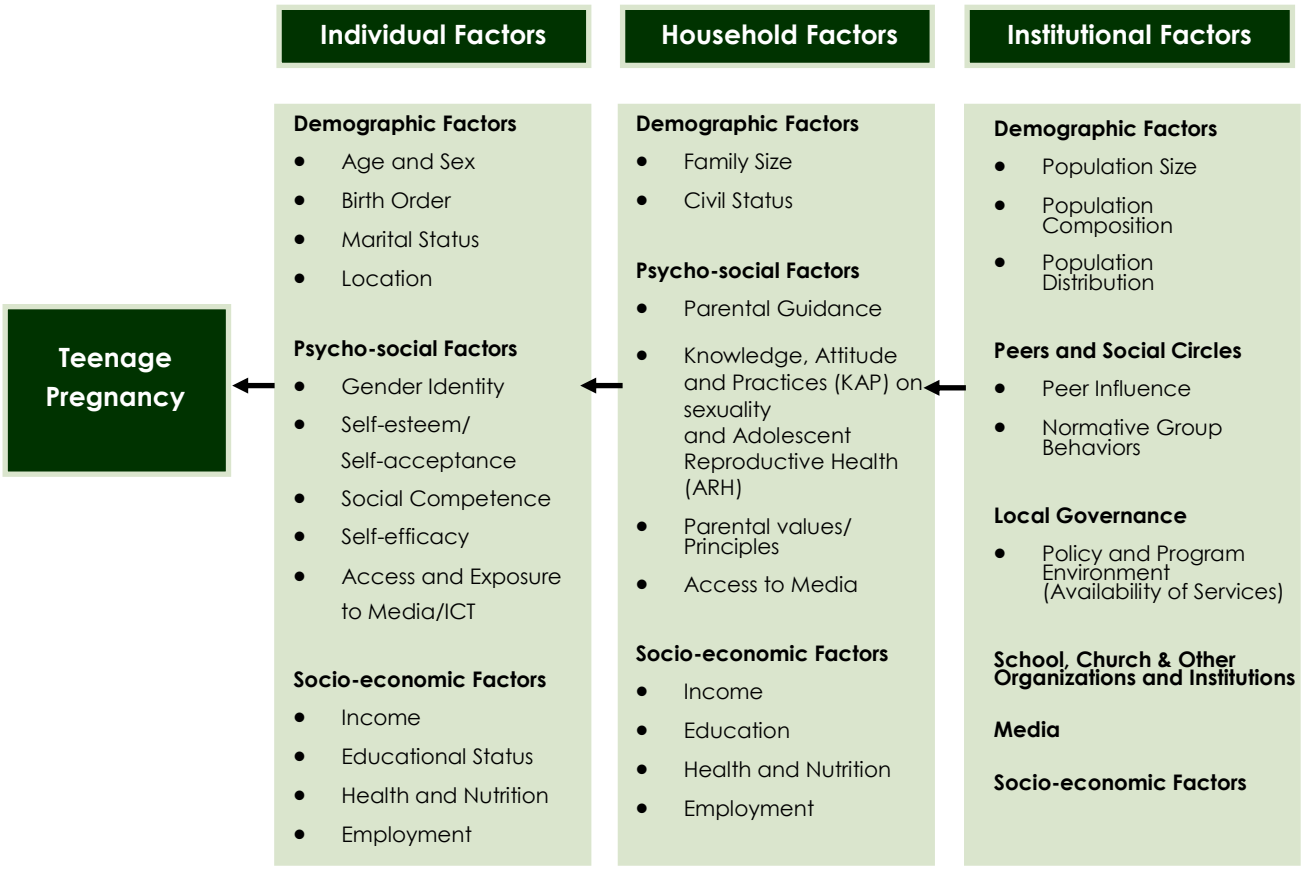


SECTION 2
DEFINING ISDN FOR AHD

WHAT IS ISDN FOR AHD?

The issues besetting adolescents and young people are complex and interrelated. For example, the increasing incidence of teenage pregnancy is caused by many interacting factors as illustrated in Figure 1. At the individual level, the interplay of demographic, psychosocial, and socio-economic factors directly impact on the sexual behaviors of young people. These factors are, in turn, influenced by several factors at the household and community levels.

Figure 1. Causal Factors of Teenage Pregnancy



Given the intricacies and the multi-dimensional nature of the factors causing teenage pregnancy and other issues affecting adolescents, addressing these concerns entails multi-sectoral and multi-faceted interventions. A one-size-fits-all approach is not viable in the context of the evolving contexts and needs of the young people today. A broader perspective in understanding the various factors affecting a certain issue affecting adolescents is necessary to effectively address such concerns.

The complex and multifaceted nature of adolescent issues also implies the need for multi-sectoral and inter-agency approach in dealing with them. It entails a collaborative and collective action by the different stakeholders to simultaneously address the various factors affecting certain issues. For instance, teenage pregnancy is not only a health concern that can solely be addressed by health offices (e.g. local health office), it also requires interventions from other institutions (e.g. local population office, etc.).

Given this, the challenge in effectively addressing teenage pregnancy and other adolescent issues is harmonizing and collectively mobilizing actions and resources to achieve a common purpose or objective. Experience has shown that a functional mechanism that converges and mobilizes key players and stakeholders into a united and collective purpose and action creates greater impact than when each stakeholder does its work in isolation. It is within this context that the **Information and Service Delivery Network for Adolescent Health and Development (ISDN4AHD)** becomes relevant.

The **ISDN4AHD** refers to the network of facilities, institutions, and service providers within the provincial, district and municipal/city health and social system providing information, training, and core service packages of health and social care for adolescents in an integrated and coordinated manner. It is a coordinative and collaborative mechanism that facilitates a harmonized and complementary interventions from different stakeholders in a locality. At its core is a referral system that links key actions and services among the members of the ISDN to ensure the continuum of care, services, and information needed by adolescents in the ISDN area. The ISDN, to be functional, needs a common appreciation and understanding among the members on the various issues and concomitant factors affecting adolescent issues in the locality. It is from this understanding that they build their shared and common purpose for the young people. Such include a united resolve to achieve these objectives through a collective and more comprehensive interventions. The ISDN approach likewise promotes greater efficiency in resource allocation by pooling and mobilizing available resources from various stakeholders.

As a collaborative mechanism, ISDN serves as a coordinative structure that plans and ensures that all aspects of specific strategies or interventions are covered and that accountability or roles of each member are defined and agreed upon. It also collectively monitors the implementation of agreed strategies and resolves emerging implementation concerns. Furthermore, it also identifies possible sources of resources (i.e. funds, human resource, technology, etc.) to implement certain strategies.

The members of the ISDN are connected through a **referral system** which ensures the continuum of information and services needed by the adolescents. Each member of the ISDN defines the services it offers as an institution or facility and links such services to the overall package of services the ISDN is offering. Each member refers adolescent clients to other members for specific services when it cannot provide the needed service by it-self or if the issues or needs of the clients requires higher level of health care or intervention.

WHY THE NEED FOR ISDN4AHD?

The ISDN approach to address adolescent health and development concerns offers significant advantages. These include the following:

1. **It fosters shared vision, objectives, accountabilities, and ownership.** The ISDN promotes collaboration among key stakeholders. With all stakeholders involved in collectively understanding the needs of the adolescents, identifying key interventions, and monitoring and evaluating agreed mechanisms for implementation, each member becomes more accountable not only for its contribution but to the shared vision and goals of the organization. Involving key stakeholders is also an expressed recognition of their critical role and contribution to the identified adolescent issues within the locality.

2. **Together, Each Achieves More (TEAM).** Team approach to address issues always works better. If most of the stakeholders are involved, goals and objectives can be achieved more efficiently and effectively.

3. **It promotes the pooling and sharing of resources** (e.g. funds, structures, facilities, equipment, human resources, and expertise, etc.). With more partners within the structure, more resources can be pooled and mobilized. Resources are always limited but if available resources are shared and pooled, it can be mobilized effectively to achieve a common goal.

4. **It ensures a more comprehensive and holistic services** (e.g. types of services, coverage). With more services included in the ISDN, adolescents are given a wider range of services they need. The continuum of services is likewise ensured through a referral system.

5. **It facilitates a more efficient monitoring and evaluation system.** Through participatory monitoring and evaluation, a wider and more objective perspective in assessing the effectiveness of the interventions can be ensured. With more efficient monitoring and evaluation, interventions are effectively enhanced.

WHAT AGENCIES COMPOSE THE ISDN4AHD?

The ISDN consists of different agencies and facilities that are providing information and services that address various issues affecting the adolescents in the locality such as teenage pregnancy, STI and HIV/AIDS, psycho-social issues, substance abuse, violence against women and children, among others.

The ISDN may be specifically composed of the following:

- Local Health Office;
- Local Population Office;
- Local Social Welfare and Development Office;
- Sangguniang Kabataan;
- Relevant CSOs operating in the ISDN area;
- Relevant private companies providing services to adolescents;
- Local Department of Education or representatives from schools from both public and private;
- Development partners (i.e. funding agencies);
- Public and private health facilities;
- Regional agencies (e.g. Department of Health (DOH), Commission on Population and Development (POPCOM), Department of Social and Welfare Development (DSWD), National Youth Commission (NYC), Department of Labor and Employment (DOLE), Technical Education and Skills Development Authority (TESDA), etc.); and
- Other institutions or organizations providing information and services to adolescents in relation to the needs identified by the ISDN.

The ISDN may include other partner institutions or facilities as they deem important in delivering needed information and services to adolescents.

WHAT ARE THE ROLES AND FUNCTIONS OF THE ISDN?

The ISDN primarily serves as a technical advisory in ensuring the continuum of information and services needed to address the prevalent issues besetting young people in the locality as mentioned above. It shall perform the following specific functions:

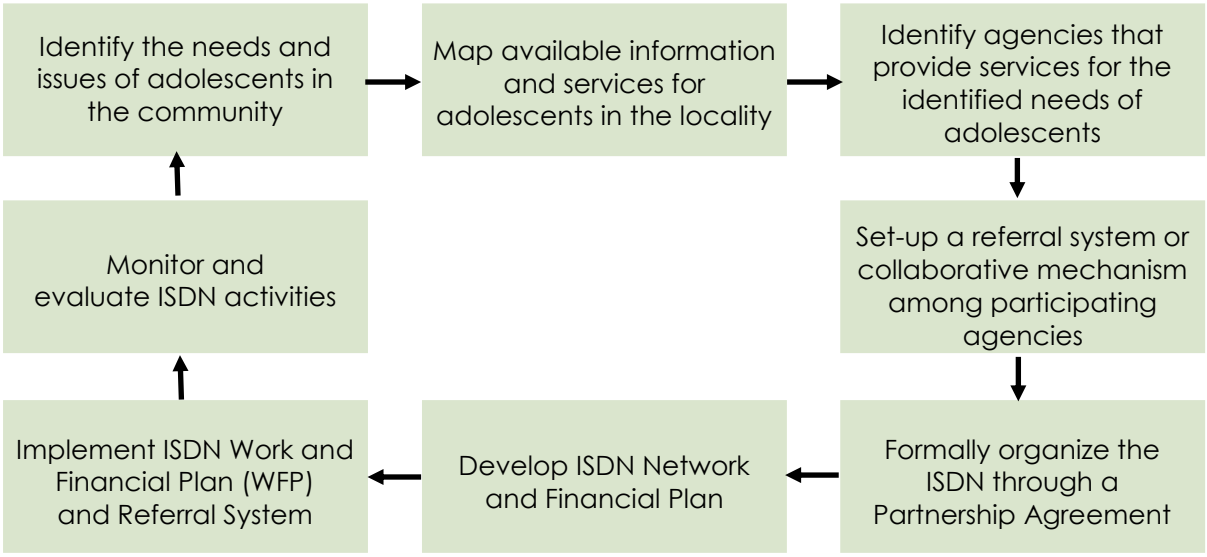
1. Convene and mobilize partners to collectively operationalize the ISDN including the:
   - identification of critical development issues among adolescents in the locality;
   - mapping of available facilities, institutions, and services;
   - provision of information and services; and
   - monitoring and evaluation of ISDN initiatives.
2. Formally establish and maintain a functional collaborative and referral mechanism to ensure availability of information and services for adolescent health concern within the ISDN area.
3. Develop, plan, coordinate, and conduct joint and collaborative projects and program on adolescent health and development.
4. Generate and share resources for the sustainability of ISDN collaborative strategies;
5. Resolve emerging implementation concerns.
6. Establish and undertake monitoring and evaluation activities for the enhancement of strategies for adolescent health and development.

The roles and functions of the ISDN may be expanded based on the identified issues and its corresponding interventions. The roles of each member shall depend on their mandates, thrusts, information and services rendered, available resources, and expressed commitments. Such roles are defined and committed through a **Partnership Agreement**.

HOW TO ORGANIZE AND MOBILIZE THE ISDN4AHD?

Setting-up the ISDN entails consultation and coordinative work with key stakeholders in every step. Figure 2 shows the overview of the various steps in establishing and mobilizing the ISDN.

Figure 2. Steps in Setting-up and Mobilizing ISDN



Identify the needs and issues of the adolescents. The first step in organizing an ISDN is to understand the issues and needs of adolescents in the locality. This requires an analysis of empirical evidence using available data and consultations with various stakeholders. A short list of agencies or institutions may be initially invited during the consultations.

Map available information and services for adolescents in the locality. After identifying the needs of the adolescents, available information and services addressing such issues and concerns are to be mapped out to see the completeness or comprehensiveness of such interventions. Needs that are without corresponding services or interventions are identified as gaps and shall be the basis for identifying new strategies. The available services shall be further assessed in terms of their coverage, thematically and geographically, to determine areas for enhancement.

Identify agencies that can provide the needed services. After mapping the available interventions vis-à-vis the identified needs, interventions to address the gaps shall be developed. This includes agreement in terms of the key strategies to be undertaken and the primary providers of needed services including those that were not included in the initial consultations.

Set-up a referral system and collaborative mechanism. After identifying the key strategies, the available services, and possible service providers, other relevant agencies or organizations identified as important in the provision of the needed services may be invited. The group shall then draw and set-up an effective referral and collaborative system to be implemented.

Organize the ISDN through a Partnership Agreement. The group formally organizes the ISDN through a Partnership Agreement which defines the shared vision and objectives, the roles and functions of each member, and the referral system or collaborative mechanism among its members. Local policies such as ordinances or executive orders may also be pursued and issued to support the establishment of the ISDN in the locality.

Develop and implement ISDN Work and Financial Plan (WFP). The ISDN formulate its work and financial plan at least for a year to concretely identify activities to be implemented, the budget requirements, and the source of needed resources. The plan spells out the specific activities to be done jointly by all members or independently by each member.

Monitor and Evaluate. The ISDN needs to conduct monitoring and evaluation activities to ensure that objectives of the structure is achieved according to plan. The inputs from monitoring shall likewise be used for addressing emerging concerns and enhancing critical areas. An agreed results matrix shall be the basis of all monitoring and evaluation activities.

WHAT IS A TEEN CENTER?

A Teen Center is an integrated and comprehensive facility that provides appropriate information, skills, and services to adolescents and young people. It is a one-stop-shop facility that aims to improve access of adolescents to appropriate information and services. The Teen Center may be situated in schools and in communities. It is usually managed through a partnership of young people and adult service providers.

The Teen Center may serve as a convergent facility of the ISDN. This means that members of the ISDN can extend their services within the center.

SECTION 3

UNDERSTANDING THE NEEDS AND ISSUES OF ADOLESCENTS IN THE COMMUNITY

SECTION 3

UNDERSTANDING THE NEEDS AND ISSUES OF ADOLESCENTS IN THE COMMUNITY

WHY THE NEED TO UNDERSTAND ADOLESCENT ISSUES?

The basic step in setting-up an ISDN is understanding the issues and needs of the adolescents who are the primary beneficiaries. It is from a deep understanding of these issues where appropriate and effective interventions may be drawn. Specifically, there is a need to have an in-depth understanding of the various issues affecting adolescents in the locality as the initial step for establishing the ISDN because of the following reasons:

1. **Adolescents' needs and issues are complex and interrelated**. The nature of the issues and concerns besetting young people today are complex and intricately interconnected. As such, a careful analysis and understanding of the inter-relationships of the various factors affecting the behavioral and non-behavioral concerns of adolescents is needed to effectively identify areas that need to be addressed. With the intricacies of these factors, it is important to identify how these factors affect each other so that more appropriate and strategic interventions can be developed and implemented. This is based on the principle that "What we know limits what we can do." With a broader understanding of the context within which the ISDN shall be mobilized, more comprehensive and holistic interventions can be designed and decision-making can be more objective and efficient. It is also from the identified and verified factors where collaborative mechanisms can be drawn and set-up.

2. **It is needed to ensure greater effectiveness and equity impact of AHD programs and projects.** The situational analysis for the needs of adolescents in the locality also involves the identification of the segment of young people who are most vulnerable and seriously affected by certain issues. With focus to those who are mostly affected by problems, greater equity can be achieved.

3. **Greater efficiency in resource allocation and mobilization.** When specific needs are identified and prioritized, investments are focused on interventions that have greater impact. As such, limited resources are channeled where it matters most, thereby, minimizing wastage of resources and loss of opportunity cost and optimizing the available resources.

HOW TO ANALYZE THE CURRENT SITUTATION OF ADOLESCENTS?

The following key steps may be undertaken for the analysis of the various issues affecting adolescents within the locality:

1 ESTABLISH A BASIC DATABASE ON AHD THROUGH FORMATIVE RESEARCH (USING PRIMARY OR SECONDARY DATA)

WHO:

Primary Researcher. A baseline data on the various indicators of Adolescent Health and Development may be initiated by the office in-charge of AHD initiatives in the locality (e.g. local population or health office; *Sanggunian Kabataan*; etc.). The researcher may also partner with other local or regional offices (e.g. POPCOM, DOH, NYC) or an academic institution particularly for technical assistance (e.g. development of data gathering tools, data gathering and processing, and analysis).

Respondents. Depending on the needed information, the primary respondents to the primary data gathering may be from the following groups:

- Adolescents (e.g. target beneficiaries);
- Significant adults (e.g. parents, teachers, service providers, barangay officials, youth organizations);
- Program implementers (e.g. local health facilities, etc.); and
- Other type of respondents identified to provide necessary information in understanding the situation of adolescents in the locality.

WHAT:

Formative research is a study before the design and implementation of an intervention. It looks at the individual interests, attributes, characteristics, attitudes, and behaviors of young people within the locality. It also aims to generate information about the community and contexts within which the target beneficiaries are living. It helps in the following:

- Defining and understanding the segment of adolescents who are at greatest risk of emerging issues within the locality (e.g. teenage pregnancy);

- Providing information needed in the design of programs that are specific to the needs of adolescents;
- Ensuring programs are acceptable and feasible to clients before launching; and
- Building a sense of participation and ownership among potential beneficiaries of interventions to be implemented in the locality.

Formative research should be an integral part of developing or adopting programs and may be used while the program is ongoing to help refine and improve program activities.

The purpose of formative research is to establish a baseline data and information from which decisions involved in the design and development or continuing enhancement of a program are based. It can be done through qualitative and quantitative research.

HOW:

Qualitative research is a scientific method of observation that gathers non-numerical data. It aims to describe meanings, concepts definitions, characteristics, metaphors, symbols, nature, and events and not to their "counts or measures." Two of the most common approach to qualitative research are **Focus Group Discussions (FGDs)** and **Key Informant Interviews (KIIs)**.

- **Focus Group Discussions** pertain to the gathering of information about a certain topic from a selected group consisting of a number of participants usually with common characteristics. It uses focus questions to which every member of the group responds based on their opinions and experiences.

- **Key Informant Interviews** also referred to as In-Depth Interviews are one-on-one discussions intended to generate a picture of the individual participant's perspective or views about the area of interest.

Quantitative Research. Quantitative research involves the use of computational, statistical, and mathematical methods to measure or quantify certain problems or phenomenon and understand how prevalent it is by looking for projectable results to a larger population.

Quantitative research may use primary and secondary data. **Primary data** is one which is collected for the first time by the researcher while **secondary data** is the data already collected or produced by others.

Specific Steps in Conducting a Formative Research. The following activities may be undertaken in the organization and conduct of qualitative formative research for the ISDN:

1. **Organize a Research Team.** Gather persons that can help in the conduct of formative research and form them into a research team. The members of the team may include technical staff (which may come from different local offices) who has the following skills:

- With basic knowledge and experience on research and data analysis; and
- With basic or substantive exposure on adolescent health and development issues or programs and with basic knowledge in interpreting AHD-related indicators.

Request technical assistance from relevant regional government agencies such as POPCOM, DOH, DSWD, DepEd, or civil society organizations (CSOs) or academic institutions in the locality if needed.

2. **Identify the needed information.** Identify the needed information for the baseline database that can be used to analyze the current situation of the young people in the locality. Some of the major indicators needed for the establishment of the ISDN are provided in Table 1 below. Use the table to gather the latest available data for relevant indicators.

Table 1. Baseline AHD Indicators

Indicators	Description	Latest Data	Source
OUTCOME INDICATORS			
1. Total number of population aged 10-19	Total count of adolescents in a locality		• Census of Population (PSA) • Community-Based Monitoring System (CBMS) • Local Socio-Economic Profile (SEP)
2. Percentage of population aged 10-19 to the total population	Total number of population aged 10-19 over the total population of the locality		• Census of Population (PSA) • CBMS • Local SEP
3. Total number of population aged 10-19 by age group	Total count of adolescents by 5-year age group (e.g. 10-14 and 15-19)		• Census of Population (PSA) • CBMS • Local SEP

Indicators	Description	Latest Data	Source
OUTCOME INDICATORS			
4. Total number of population aged 10-19 by geographic location	Total count of adolescents in every local government unit (i.e. municipality/ city/ barangay)		• Census of Population (PSA) • CBMS • Local SEP
5. Sex ratio of adolescents	Number of adolescent boys for every 100 girls		• Census of Population (PSA) • CBMS • Local SEP
6. Percentage of adolescents by marital status	Percentage of adolescents who are single, married, and living-in or in cohabitation		• Census of Population (PSA) • CBMS • Local SEP
7. Adolescent birth rate	Number of live births among adolescents (10-19) per 1,000 adolescents in the locality		• Local health or population office • Local civil registrar
8. Percentage of adolescents by highest educational attainment and by sex	Percentage of adolescents who have received elementary, secondary, or college education		• City/Municipal Division Schools • CBMS • Local SEP
9. School participation rate or enrollment rate	Percentage of adolescents who enrolled in the current school year (over the total number of adolescents)		• City/Municipal Division Schools • CBMS • Local SEP
10. Number of out-of-school youth (per LGU)	Number of adolescents who are not currently in school		• Local Social Welfare Development (SWD) Office • CBMS • Barangay Profile • Local SEP
11. Youth employment rate	Percentage of youth (aged 15-24) who are gainfully employed for the last six months		• Regional Department of Labor and Employment (DOLE) Office • Local SEP

Indicators	Description	Latest Data	Source
OUTCOME INDICATORS			
12. Youth unemployment rate	Percentage of youth (aged 15-24) who are not gainfully employed or who are not looking for job for the last six months		• Regional DOLE Office • Local SEP
13. Morbidity rates (per disease) among adolescents	Percentage of adolescents who experienced specific disease within a year		• Local health office/ facilities
14. Number of maternal deaths among adolescent girls	Number of adolescent girls who died because of pregnancy and childbirth-related causes		• Local health office/ facilities
15. Number of adolescents infected with STI or HIV/AIDS	Number of adolescents who were infected with STI or HIV/AIDS in a particular period		• Local health office/ facilities
16. Number of adolescents with Reproductive Health (RH) problems	Number of adolescents who have RH problems		• Local health office/ facilities
17. Proportion of stunted children 10-14 years old	Proportion of children aged 10-14 who are stunted over the total number of children of same age		• Local health office • National Nutrition Survey - Food and Nutrition Research (FNRI)
18. Percentage of children aged 10-14 who are malnourished	Percentage of children aged 10-14 who are malnourished over the total number of children of the same age		• Local health office • National Nutrition Survey - FNRI
19. Crime rate among adolescents	Percentage of adolescents who were reported to have committed crimes over the total number of adolescents		• Barangay profile • Philippine National Police (PNP) report
20. Percentage of adolescents who have experienced any type of violence	Percentage of adolescents who reported to have been inflicted with any type of violence (e.g. physical, sexual, psychological, etc.)		• Local PNP report • Local SWD Office

Indicators	Description	Latest Data	Source
OUTCOME INDICATORS			
21. Number of adolescents who are at risk status: Homeless Commercial sex worker, Hazardous jobs	Number of adolescents who were reported in at risk situations		• Local PNP report • Local SWD Office
SERVICE UTILIZATION INDICATORS			
1. Number of adolescents who accessed family planning services	Number of adolescents provided with any method of family planning		• Local health office/ facilities
2. Number of adolescents accessed any health services from health facility	Number of adolescents provided with any health services from health facilities in the locality		• Local health office/ facilities
3. Number of pregnant adolescents who have accessed pre- and post-natal services	Number of pregnant adolescent girls who had at least four visits during their pregnancy		• Local health office/ facilities
4. Number of adolescents provided with scholarship	Number of adolescents provided with scholarship from various sources		• Local schools
5. Number of adolescents provided with infor-mation on ASRH	Number of adolescents provided with information on ASRH		• Local schools • Local health and population offices
6. Number of parents and teachers trained on ASRH	Number of adults (parents/teachers who have been trained on ASRH-related topics)		• Local population or health offices
OTHER BEHAVIORAL INDICATORS			
1. Percentage of adolescents who have ever taken alcohol and illegal drugs	Number of adolescents who have ever taken substances (alcohol and illegal drugs)		• Local health office • Local PNP reports • Barangay incident reports
2. Percentage of adolescents who have engaged in sexual activities	Number of adolescents who have already engaged in sexual activities		• Local health or population office

OTHER QUALITATIVE INFORMATION ON AHD

1. Attitude about engagement of adolescents in sexual activities;
2. Types of activities adolescents usually engage in especially during their free time with their peers;
3. Reasons why adolescents engage in non-sexual risky behaviors such as smoking, drinking, and use of illegal drugs;
4. Types of activities adolescents engage in when they are with their boyfriend or girlfriend;
5. The place where adolescents usually engage in sexual activities with their boyfriends and girlfriends;
6. Reasons or factors why adolescents engage in sexual risky behaviors;
7. Sources of their information about sexual and reproductive health;
8. Reasons why adolescents do not use contraceptives when they engage in sex; and
9. Reasons why adolescents do not visit or access health services from health facilities.

3. Identify information gap. Based on the baseline data and information gathered for the listed indicators, identify the indicators without available data. These indicators indicate the information gaps that the team needs to gather to have a more comprehensive information about the adolescents in their locality. Information gaps also pertains to other information necessary for setting-up the ISDN although not listed in the table above.

4. Decide on what type of data gathering methodology to use. Depending on the gaps in the available information, decide to conduct qualitative or quantitative research to gather the needed information.

A. Activities and Considerations in Conducting FGDs and KIIs (Qualitative Study)

i. Identify respondents and number of FGDs or KIIs. Based on the identified information gaps, identify the type of respondents who could provide the needed information. In identifying the type of respondents and the number of FGDs and KIIs needed, consider the homogeneity or sameness of the relevant characteristics of the participants and the saturation of the responses to more completely understand the issue or the information needed. When the final FGDs or KIIs do not reveal new insights or ideas anymore, saturation has been reached. It is also important to consider the number of the respondents in an FGD. On average, six to 12 people participate in each FGD because fewer than six participants produce less than a critical mass of discussion and interaction; groups larger than eight to 10 people can be hard to manage and it can be difficult to give everyone a chance to voice their opinions.

ii. Develop guide questions. After identifying the types of the respondents, start drafting a list of questions that match the research objectives and the identified respondents. Review the purpose and objectives of the study and the information needed after finalizing the questions. The list of questions may be narrowed to the ones that are most relevant and important for the research, ideally seven to 10 questions, with the consideration that each question will be followed by additional probing questions. Some probing questions may also be crafted to validate and deepen the understanding of the research team on the underlying causes of the issue or behavior being discussed. The FGDs or KIIs should not be overloaded with too many questions.

An FGD will generally last for one to two hours and an in-depth interview is usually shorter. The goal of qualitative research is to go deep into a few key ideas, not to cover a lot of topics superficially. Good FGD questions are those that are open-ended (i.e., they cannot be answered simply by "yes" or "no") or those that invite ideas and stimulate conversation. Questions should not be biased and do not have language that might encourage participants to answer in a specific manner.

Once focus questions are refined and finalized, arrange them in such a way that it begins from the more general to the specific and in a way that will be comfortable for the participants. The first one or two questions should be simple introductory or warm-up questions that put the respondents at ease, help establish rapport between them and the interviewer, and lead into the more serious questions.

iii. Select or assign facilitators and interviewers. From among the members of the research team, select or assign facilitators and interviewers for specific types of respondents. Assign an additional person who can take notes on the discussion so the facilitator is free to moderate the discussion.

iv. Develop a script. In addition to the focus questions, formulate a script to ensure standard messages from the opening to the closing parts of the FGDs or KIIs. The script may contain an opening statement which provides the introduction of the participants; explanation of the background and objectives of the FGDs or KIIs; securing the consent from the respondents for sharing and recording of the information from them; assuring confidentiality of the information to be generated; and laying of certain ground rules in the conduct of the FGD. The script may also contain a closing statement to summarize some general themes and insight that came out of the conversation and for the final words of the participants. *(Please see Annex A for sample FGD and KII Guide)*.

v. Select a conducive place or venue for the FGD. Before proceeding with the FGDs and KIIs, ensure that a conducive place is selected for the FGDs and KIIs. The venue should be accessible to the respondents; ensures privacy and confidentiality of the discussions; and ensures comfort or is facilitative to open discussion, large enough for the number of participants, and free from internal and external distractions.

vi. **Conduct the FGDs and KIIs.** After all necessary arrangements are coordinated with respondents and other partners, conduct the FGDs and KIIs as scheduled. Consider the following in the conduct of the FGDs and KIIs:

a.) Open the FGDs and KIIs by welcoming and introducing the facilitators and respondents. Explain the purpose of the activity and ensure them of the confidentiality of information to be gathered. Ask for their consent to the recording of the discussion.

b.) Effective facilitation and interviewing should be able to create personal rapport and trust that will enable the participant to honestly share his/her opinions and feelings.

c.) Both facilitators and interviewers should be able to effectively keep the discussion on track and ensure that every participant is able to voice out his/her opinions or ideas about the question.

d.) Facilitators should be open-minded, flexible, patient, observant and good listeners and ensure that they do not lead or influence the conversation. They need to be able to capture and follow on trends in the conversation and use active and reflective listening. They should also internalize the subject and objectives of the FGD or KII so that he or she can help keep the conversation centered on the purpose and needs of the study.

e.) The documenter should be able to note all important inputs from the respondents. Record the entire conversation with an audio or digital recorder.

f.) Close the FGD and KII by thanking the respondents for their participation and reassuring them that the information gathered will be used only for the purpose of the study.

vii. **Transcribe the discussions and interviews.** Once the FGD or KII is finished, write down any impressions or observations made during the discussion or interview that might help the analysis. This might include messages from the non-verbal gestures of the respondents. The audiotape of the discussions should be carefully transcribed and, if needed, translated. The more immediate an FGD or In-depth Interview (IDI) is transcribed, the more accurate the transcription is.

viii. **Analyze the information gathered through FGDs and KIIs.** Results of the FGDs and KIIs should be analyzed and coded for common themes and messages in relation to the purpose and objectives of the study. These findings should be put into a report that details the methods of the study, the key results and findings of the discussions and/or interviews, and the resulting implications as they relate to the design of the health campaign or program.

B. Activities and Considerations in Conducting Quantitative Survey.

There are several types of quantitative study which includes the following: descriptive, correlational, experimental, and quasi-experimental. The differences between the four types primarily relates to the degree the researcher designs for control of the variables in the experiment.

i. **Form a research team and identify information gap.** Similar to the basic steps discussed for the qualitative research or conduct of FGD and KII, form a research team that will take the lead in the conduct of the survey. From the baseline AHD information, identify data that needs to be gathered.

ii. **Identify the research problem and objectives.** Based on the needed information identified in the first step, formulate the research problems or questions that need to be investigated.

From the research questions, identify variables to be collected through the survey instruments. The research problem likewise determines the type of respondents from which information will be gathered.

Research problems are likewise formulated based on the review of relevant literature and theoretical framework that guides the identification and understanding of needed variables and their interrelationships.

From the research problems, formulate the research objectives. Research objectives define the specific research needs.

iii. **Formulate the questionnaire.** Based on the research questions, formulate a comprehensive survey instrument for identified respondents. Ensure that each question in the survey helps in answering the research questions or objectives. A sample survey questionnaire can be downloaded from the k4health website (https://www.k4health.org/toolkits/measuring-success/guide-monitoring-and-evaluating adolescent-reproductive-health-programs). The questionnaire may be pre-tested to assess its effectiveness in gathering the needed information.

iv. **Identify study population or sampling of respondents.** For purposes of establishing a baseline data through formative research, the convenience sampling method may be applied for the survey. This is used in exploratory research where the researcher is interested in getting an inexpensive approximation of the truth. As the name implies, the sample is selected because they are convenient. This nonprobability method is often used during preliminary research efforts to get a gross estimate of the results, without incurring the cost or time required to select a random sample.

The number of respondents to the survey will likewise be based on the available resources.

v. Decide what data gathering methods to use. Determine the method for gathering the data from respondents. Decide whether to use self-administered questionnaire or interview with respondents personally or via phone or online.

vi. Conduct the survey

a.) Ensure that appropriate respondent is interviewed based on the criteria set by the research team.

b.) Similar to the qualitative research, explain the purpose of the survey to the respondents; secure their consent (for adolescents below 18 years old, secure the consent of the parents); and assure them of the privacy and confidentiality of the information to be gathered from them.

c.) Check accuracy, consistency, and completeness of responses before closing the interview.

VI. Encode, process, and analyze the data

a.) Develop a database for encoding of the responses using available statistical software program (e.g. SPSS or MS Excel).

b.) Clean the data by checking the consistency and accuracy of the responses before encoding.

c.) Depending on the available resources, hire encoders to facilitate more expeditious encoding of the data.

d.) From the encoded dataset, start to analyze the data by processing or producing summary descriptive tables or graphical presentations of all the variables based on the research questions. Out of the data, deduce certain observations and patterns or make some interpretations of the data and their interrelationships with other variables. Focus on identifying evidences for emerging issues and concerns among adolescents.

e.) Present the results into a narrative or processed data particularly for the purpose of identifying the issues of adolescents in the locality.

Packaging the baseline data into useful information for ISDN planning

1. After gathering and analyzing the primary and secondary data on AHD, package the information as a reference for decision-making processes particularly during the consultation workshops with stakeholders.

The data may be summarized into the following matrix:

Observations	Causes
Example: 1. High incidence of teenage pregnancy (30%)	• High proportion of adolescents engaging in sexual intercourse (35%) • High incidence of sexual violence among girls (15%)
2. High proportion of Optimum Sustainable Yield (OSYs)	• High incidence of teenage pregnancy (30%)

2 ORGANIZE A CONSULTATION WORKSHOP FOR AHD SITUATIONAL ANALYSIS

WHO:

Organizer. The consultation workshop can be organized or coordinated by the office in-charge of AHD initiatives in the locality (e.g. local population or health office; *Sanggunian Kabataan*; etc.). The organizer may also partner with other local or regional offices (e.g. POPCOM, DOH, NYC) particularly for technical assistance (e.g. facilitation and processing of the workshop outputs).

Participants. The organizer may invite all offices and agencies that are providing all sorts of information and services or programs to adolescents within the locality. The number of participants may depend on the available resources of the organizer/s, ensuring that agencies within the locality can respond to the major thematic concerns (e.g. teenage pregnancy, employment, drop-out, etc.) of adolescents are represented in the meeting.

WHAT:

The consultation workshop provides the venue for the identification and analysis of the key issues and causal factors involving adolescents within the locality. It aims to generate priority issues that can be responded to by the interventions of the ISDN.

HOW:

1. Identify and invite all relevant agencies and institutions both from the public and private sectors. List and create a directory of all agencies that are providing or are dealing with various sectoral issues and concerns of adolescents in the locality. Include regional and local institutions. Invite representatives from these institutions to participate during the scheduled consultation workshop. Invite a presider or overall moderator who can direct the discussion towards the identification of priority issues among adolescents.

2. Conduct the Consultative Workshop. During the actual workshop, orient the participants on the following objectives of the activity:

a.) To validate and analyze the various issues causing these concerns among adolescents in the locality;

b.) To prioritize the issues and its causal factors;

c.) To identify the segment of adolescents who are mostly affected by the specific issues identified;

a.) To initially identify existing interventions or programs that are implemented within the locality in relation to the issues; and

b.) To initially identify key stakeholders in relation to the issues.

Identify facilitators who can direct the discussions and generate useful responses from the participants. The facilitators may be from other relevant regional or local agencies.

Before the workshop proper, present the initial AHD situationer packaged through the baseline data gathered. Invite clarification and additional inputs from the participants. The presentation can serve as a basis for the succeeding workshop groups.

For the workshop proper, the following mechanics may be adopted:

a.) The participants may be divided into sectoral concerns: health and nutrition, sexual and reproductive health, education and training, employment, gender-based violence, social welfare and other relevant sectoral issues among adolescents.

b.) Each group shall identify and analyze the key issues and their causes using the following approaches and tools:

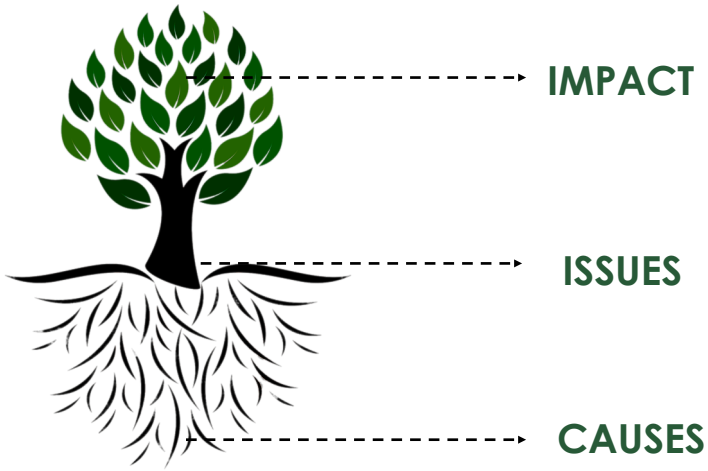
CASUAL TABLE

Issues	Causes	
	Direct/Immediate	Indirect/Underlying
Example: High incidence of teenage pregnancy	Engagement in unprotected sex	• Access to pornographic materials • Lack of access to contraceptives

NOTE: *Direct or immediate causes* refer to things, persons, activities or actions, events, and conditions that directly, or without intervening factors, produced the current or resulting outcome. *Indirect or underlying causes* pertain to those that caused the resulting outcome or condition through intervening factors (i.e. direct factors).

OTHER METHODOLOGIES FOR SITUATIONAL ANALYSIS

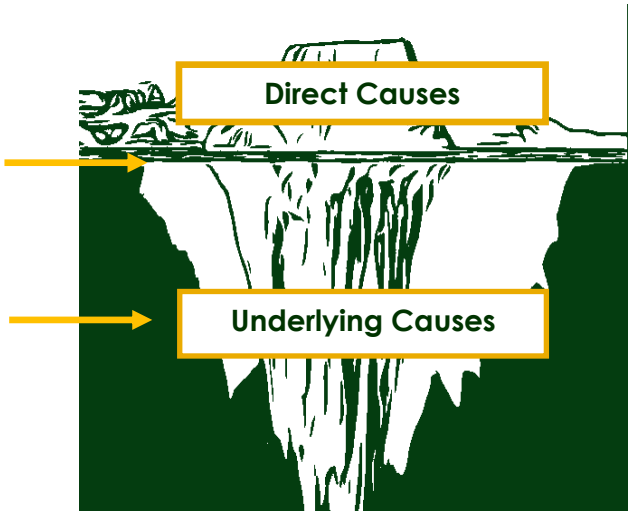
I. PROBLEM TREE



II. ICEBERG APPROACH

- High incidence of Teenage Pregnancy → Problem Manifestation? (What is happening?)

- Early engagement to unprotected sex
- Lack of information on ASRH
- Peer Pressure
- Inability of girls to refuse or negotiate with their partner



III. "KEEP ASKING WHY"

In understanding the causes of a problem, probe for the factors affecting the issue until the root cause has been identified or the information provides a deep basis of the identification of appropriate intervention.

Observation: There is an increasing incidence of teenage pregnancy (from 6.3% in 2004 to 13.2% in 2013)	
High proportion of adolescents engaging in unprotected sex	**WHY?**
High proportion of male adolescents who have accessed pornographic materials	**WHY?**
Lack of parental guidance	**WHY?**
Parents do not want or unable to discuss sexuality-related concerns with their adolescents	**WHY?**
Discussing sexuality-related topics is considered as culturally taboo	**WHY?**

a. The members may write their responses in a metacard for easier processing of the responses. Ask participants to post their responses in appropriate spaces.

b. In processing the outputs from the participants, consolidate or combine common ideas. Clarify ideas from the author to be sure of the meaning or context of the concept as they are meant by the originator. Confirm and get agreement from the participants on their collective outputs.

c. Let each group present their outputs to the bigger group or to the plenary for further inputs.

3. **Consolidate the Outputs into a Working Document.** Gather the various group outputs and consolidate them into the following matrix

Issues	Causes	
	Direct/Immediate	Indirect/Underlying
Example: High incidence of teenage pregnancy	Engagement in unprotected sex	• Access to pornographic materials • Lack of access to contraceptives

The consolidated matrix shall be used for the mapping of available services and identification of appropriate interventions.

Situational Analysis using Secondary Data. In developing an AHD situational analysis, existing literature may also be used as reference.

SECTION 4

MAPPING AVAILABLE INTERVENTIONS AND SERVICES FOR ADOLESCENTS IN THE COMMUNITY

SECTION 4

MAPPING AVAILABLE INTERVENTIONS AND SERVICES FOR ADOLESCENTS WITHIN THE SOCIETY

After identifying the key issues faced by adolescents in the locality, the ISDN Secretariat (e.g. POPCOM or DOH) may map or take inventory of all available services and information interventions for health and social development of adolescents being provided by different agencies and institutions within the locality in relation to the identified needs in the consultation workshop. The inventory of these services and information may be done using the form in Annex C (AHD-Related Services Available in the Locality).

The results of the inventory and mapping may be analyzed by comparing the critical issues and needs by adolescent with the available services. The result of this analysis shall result in the gaps of available services, which shall, in turn, serve as the basis for the design of AHD appropriate interventions.

The mapping of available AHD facilities and related institutions may also be done simultaneously with the situational analysis. While the analysis of the current situation of the adolescents is being done, a parallel inventory or mapping of AHD facilities may be done by the research team.

HOW TO MAP AVAILABLE AHD INTERVENTIONS?

The mapping activity involves the listing and inventory of both AHD interventions and service facilities. AHD interventions include programs, projects, and activities being provided by government, non-government, and private organizations for adolescents or young people within the locality.

These interventions may be in school or in the community. AHD facilities, on the other hand, pertain to services being provided within a health facility which include health centers, clinics, hospitals, teen centers, and other service centers that provides on-site services. These interventions and facilities shall be mapped to identify the comprehensiveness or completeness of coverage of available interventions and services within the locality in relation to the issues identified.

The following key steps may be undertaken for the analysis of the various issues affecting adolescents within the locality:

1 CREATE AN INITIAL LIST OF ALL FACILITIES AND ORGANIZATIONS PROVIDING AHD INFORMATION SERVICES FOR ADOLESCENTS WITHIN THE LOCALITY

WHO:

Research Team/AHD Team: The research team or an AHD Team formed by the locality may lead the overall mapping of AHD interventions and facilities within the locality. As such, they shall be involved in the initial listing of all facilities and organizations providing AHD information and services for adolescents within the locality.

WHAT:

The initial listing of all AHD related organizations and facilities involves the identification of possible institutions that can provide necessary services and information that address the identified needs of the adolescents. This activity aims to have initial information on the number of institutions to be consulted as respondents to the inventory to be done. It also provides initial information on the coverage and comprehensiveness of available AHD information and services within the locality.

HOW:

Create an initial list of the institutions providing AHD services and interventions. Based on available directory, list down organizations in the locality that are providing AHD services and interventions. Institutions located outside the locality but are also providing AHD services and interventions to adolescents in the area or are accessible to them can be included in the list. The initial list may contain the name of the institution or facility, contact person, address, and contact number.

2 DEVELOP AN INSTRUMENT FOR MAPPING

WHO:

Research Team/AHD Team: The research team or an AHD Team formed by the locality develops an instrument for the generation of information about the institutions or facilities that can be included in the information and service delivery network.

WHAT:

The development of instrument for mapping involves the development of structured form to document the needed information particularly on the available AHD services and interventions implemented by different institutions within the locality. It specifically takes stock of the following information: name of institution or facility; address or location; contact information; types of AHD services or programs/projects being provided; schedule of services; types of target clients or beneficiaries; number of staff; and other information needed for establishing the service delivery network.

HOW:

Develop an instrument for the mapping. To gather comprehensive information from various facilities and institutions, develop a structured data gathering tool for the listed respondents. A sample tool for the inventory of available AHD information and services and other interventions in the locality is provided in Annex C.

3 GATHER, PROCESS, AND ANALYZE INFORMATION FROM IDENTIFIED RESPONDENTS

WHO:

Research Team/AHD Team. The research team or an AHD Team formed by the locality develops an instrument for the generation of information about the institutions or facilities that can be included in the information and service delivery network.

WHAT:

This activity involves the actual data gathering process. The data gathering may be done using the instrument developed in Step 2.

HOW:

1. **Gather information from identified respondents.** Gather information using the developed tool through an interview with the facility staff or person who can provide the needed information or through self-administration (e.g. respondents fill-in the needed information in the instrument by themselves). Call backs may be done if necessary. Ensure that all needed and accurate information are provided and clarified before encoding the information in the database.

2. **Encode and make a database of the available AHD services and interventions in the locality.** As the accomplished forms are gathered, encode the information in a database to be used for analysis and development of directory. Any available application or software program (e.g. MS Excel or Word) can be used for the database. Annex D provides a sample encoding and consolidating matrix for the database.

3. **Plot and analyze the available services vis-à-vis the AHD issues and needs identified.** Analyze the results of the inventory by comparing the identified critical issues and needs of adolescents (e.g. output in Section 3 (*Understanding the Issues and Needs of Adolescents in the Community*) with the available services. The result of this analysis provides information on the coverage and gaps of available AHD services and programs in the locality. Use the output of this activity for the workshop of the ISDN on AHD program planning and referral system development. Table 2 below provides a sample matrix for mapping and analyzing available AHD services and interventions.

Using the said matrix, the issues that do not have corresponding services and programs indicates the areas that need to be responded to. Address these gaps during the ISDN action planning workshop discussed in Section 5. It also helps in identifying more specific gaps in the available services if such services are matched or compared with the identified causes in Section 3. This is to ensure that all causes of a certain problem situation will be addressed comprehensively.

Table 2. AHD Services and Programs for Specific Adolescent Issues and Needs

AHD Issues	Causes	Available Services/ Programs	Provided by (name of organization/ facility)	Geographic Coverage	Target clients/ beneficiaries
A. High incidence of adolescent pregnancies	Unprotected sex	**FP Counseling**	Brgy. Alpha Health Center	Brgy. Alpha, Beta Municipality	Women of reproductive age (15-19)
	Lack of information about ASRH	**Peer Education Program**	Municipal Population Office	Beta Municipality	Adolescents aged 10-19
B. High drop-out rate / high number of OSY	Poverty/ low family income	**Alternative Learning System**	Division School of Beta Municipality	All barangays, Beta Municipality	OSYs
C. High proportion of adolescents taking alcohol	Lack of policy measure for regulating activities of adolescents during wee hours	**Curfew Policy**	Barangays Charlie and Alpha	2 barangays, Beta Municipality	All adolescents and youth aged 10-24
D. High proportion of adolescents taking illegal drugs	Family problems or conflicts	**Peer Education Program**	Municipal Population Office	Beta Municipality	Adolescent aged 10-19
E. High proportion of children or adolescents in conflict with law	Lack of policy measure for regulating activities of adolescents during wee hours	**Curfew Policy**	Barangays Charlie and Alpha	2 barangays, Beta Municipality	All adolescents and youth aged 10-24

AHD Issues	Causes	Available Services/ Programs	Provided by (name of organization/ facility)	Geographic Coverage	Target clients/ beneficiaries
F. High unemployment rate among OSYs	Lack of skills and training among adolescents	**Technical and Vocational Education and Training (TVET) Program**	TESDA Manpower Training Center	All barangays	All adolescents and youth aged 10-24
G. High malnutrition among adolescents					
H. High malnutrition among adolescents					
I. High incidence of STI and HIV/ AIDS among adolescents					
J. High number of adolescent girls involved in prostitution					
K. High number of adolescent girls involved in prostitution					
L. High proportion of adolescents who are smoking					
M. High number of adolescents exposed in occupational hazards					

AHD Issues	Causes	Available Services/ Programs	Provided by (name of organization/ facility)	Geographic Coverage	Target clients/ beneficiaries
N. High number of sexual violence among adolescent girls					
O. Other identified AHD issues					
P. Other identified AHD issues		**Peer Education Program**	Municipal Population Office	Beta Municipality	Adolescents aged 10-19

SECTION 5

SETTING-UP AND MOBILIZING THE COORDINATIVE STRUCTURE AND REFERRAL SYSTEM FOR THE ISDN

SECTION 5

SETTING UP AND MOBILIZING THE COORDINATIVE STRUCTURE AND REFERRAL SYSTEM FOR THE ISDN

Given the comprehensive understanding of the context of the adolescent issues in the locality, the AHD group moves toward the formal organization of the ISDN particularly for the establishment of coordinative mechanism and referral system among its members and their service facilities.

HOW TO FORMALLY SET-UP THE ISDN IN THE LOCALITY?

1 MAKE A FINAL LISTING OF THE RELEVANT MEMBERS OF THE ISDN

WHO:

Local AHD Team: The local AHD Team formed by the locality lists all the institutions and facilities that can provide relevant services and information for AHD specifically those identified in the Table 2 (AHD Services and Programs for Specific Adolescent Issues and Needs).

WHAT:

This activity aims to identify the relevant agencies and institutions that could be invited to be part of the ISDN in the locality.

HOW:

1. **Review the adolescent needs and available services in the locality.** Based on the identified AHD needs in the locality, review the mapping of available services and the institutions delivering them. Check its completeness to ensure that all stakeholders are accounted for.

2. **Make the list of institutions, offices, or facilities that can be invited to be a member of the ISDN.** Based on Table 2 and the summary of the information gathered in the mapping of available AHD services using appropriate tool (i.e. Annex C), make a list of all the institutions, agencies, facilities that can be invited to form part of the ISDN.

2 CONDUCT THE ISDN ORGANIZATIONAL MEETING

WHO:

Local AHD Team: The local AHD Team, in collaboration with relevant regional agencies such as POPCOM or DOH, organizes and conducts the first organization meeting of the ISDN. Representatives participating in the meeting should be able to make decisions and commitments to ensure the efficient formation of the ISDN and initial agreement would be binding for all the participants.

WHAT:

This activity aims to initially convene the stakeholders that can possibly commit to be a member of the ISDN. It can be conducted in a number of days depending on the resources and progress of discussion among possible members. The following can be included in the agenda of the meeting or workshop:

- Presentation and discussion on the AHD issues and concerns in the locality;
- Mapping of available services and information;
- Organization of the ISDN;
- Function and responsibilities of the ISDN;
- Proposed coordinative mechanism and referral system;
- Terms of reference of each member of the ISDN as enumerated in the Partnership Agreement;
- Action Planning (e.g development of a consolidated Action Plan for the ISDN); and
- Next Steps: Formal signing and launching of the Partnership Agreement; and
  Other ISDN Activities.

HOW:

1. **Set the Agenda for the Meeting or Workshop.** Based on available resources, set the agenda of the meeting or workshop to determine the number of days required for the activity. The meeting should be conducted at least within two days. The activity may also be conducted in a series of meetings until the main desired outputs which include the referral system, Action Plan, and the Partnership Agreement are produced. Ensure that the meeting is conducted in a conducive and accessible venue for all participants. Needed presentations and materials/references should also be prepared efficiently before the meeting. Schedule the meeting or workshop on a date when most of the identified stakeholders are available.

HOW:

2. Conduct the Meeting (Discuss the Agenda). The meeting may be initially presided by the AHD Team formed by the LGU or the Office in-charge of the AHD program. Some background presentation about the ISDN may be provided as a take-off point for the discussion of succeeding agenda.

a. Present and discuss the AHD issues and concerns in the locality. The discussion should revolve around the key issues and concerns affecting young people in the locality. The initial presentation may come from the formative research and consultation workshop done by the local AHD Team. Enhance, validate, and prioritize the identified concerns as an output of the discussion.

b. Map available services and information. Present and discuss with the group the initial results of the mapping of AHD services and information. The group may validate and enhance the mapping to ensure that all available services were appropriately and completely identified.

c. Identify the Needed AHD Information Services to be Provided within the ISDN. Based on the matching of the identified issues and the corresponding available services, identify the age and development-appropriate services to be provided within the ISDN. A sample list of the AHD-related services is provided in Table 3.

Table 3. AHD-related Services

Major Services	Essential AHD Information and Services
1. General health care	a. Check-up and diagnostic services b. Dental care c. Tuberculosis, malaria, and other endemic diseases d. Injuries and accidents e. Proper nutrition and health lifestyle education and services f. Mental health services including information and services to address the use of tobacco, alcohol, and drugs g. Hygiene services

Major Services	Essential AHD Information and Services
2. Adolescent sexual and reproductive heath	a. Comprehensive Sexuality Education (CSE) in school and in communities for adolescents and concerned adults (e.g. parents, teachers, service providers, etc.) b. Family planning information and services including contraceptives c. Sexually transmitted infections testing, counseling, and treatment d. Voluntary HIV/AIDS testing, counseling, and treatment e. Maternal health care services (e.g. pregnancy care and facility-based delivery) f. Management of post-abortion complications g. Management of physical and sexual violence
3. Social welfare services	a. Foster care or substitute family care b. Management of physical and sexual violence c. Guidance counseling d. Protective services for adolescents in need (e.g. abandoned or neglected; exploited and abused; maltreated; orphaned; victims of trafficking and prostitution; adolescents in armed conflict; internally displaced; adolescents in conflict with law; and other disadvantaged adolescents) e. Day care service for working adolescents with children f. Adoption services g. Personality enhancement and positive lifestyle education h. Socio-cultural, spiritual, and physical development i. Peer-support
4. Other socio-economic development services	a. Employment and livelihood assistance and services (e.g. job placement) b. Pre-employment education and counseling c. Career planning and professional development services d. Educational services including technical and vocational trainings and education and scholarships
5. Youth community involvement and participation	a. Leadership skills development b. Citizenship and social responsibility skills development c. Volunteerism and involvement in social and community development activities

d. Organization of the ISDN. Based on the analysis of the key issues and the available services and information on AHD, the AHD Team presents the overview, roles and functions, and coordinative mechanism including the proposed referral system for discussion and approval of the group.

e. Functions of the ISDN. The ISDN primarily serves as a technical advisory in ensuring the continuum of information and services needed to address the prevalent issues besetting young people in the locality as mentioned above. It shall perform the following specific functions:

i. Convene and mobilize partners to collectively operationalize the ISDN including the identification of critical development issues among adolescents in the locality; mapping of available facilities, institutions, and services; provision of information and services; and, monitoring and evaluation of ISDN initiatives;
ii. Formally establish and maintain functional collaborative and referral mechanism to ensure availability of information and services for adolescent health concern within the ISDN area;
iii. Develop, plan, coordinate, and conduct joint and collaborative projects and programs on adolescent health and development;
iv. Generate and share resources for the sustainability of ISDN collaborative strategies;
v. Resolve emerging implementation concerns; and
vi. Establish and undertake monitoring and evaluation activities for the enhancement of strategies for adolescent health and development.

The roles and functions of the ISDN may be expanded based on the identified issues and corresponding interventions. The roles of each member shall depend on their mandates, thrusts, information and services rendered, available resources, and expressed commitments. Such roles are defined and committed through a **Partnership Agreement**.

f. Coordinative Mechanism and Referral System. An effective referral system ensures a close coordination between all levels of AHD interventions. It also ensures the adolescents optimal and comprehensive care and services at the appropriate level.

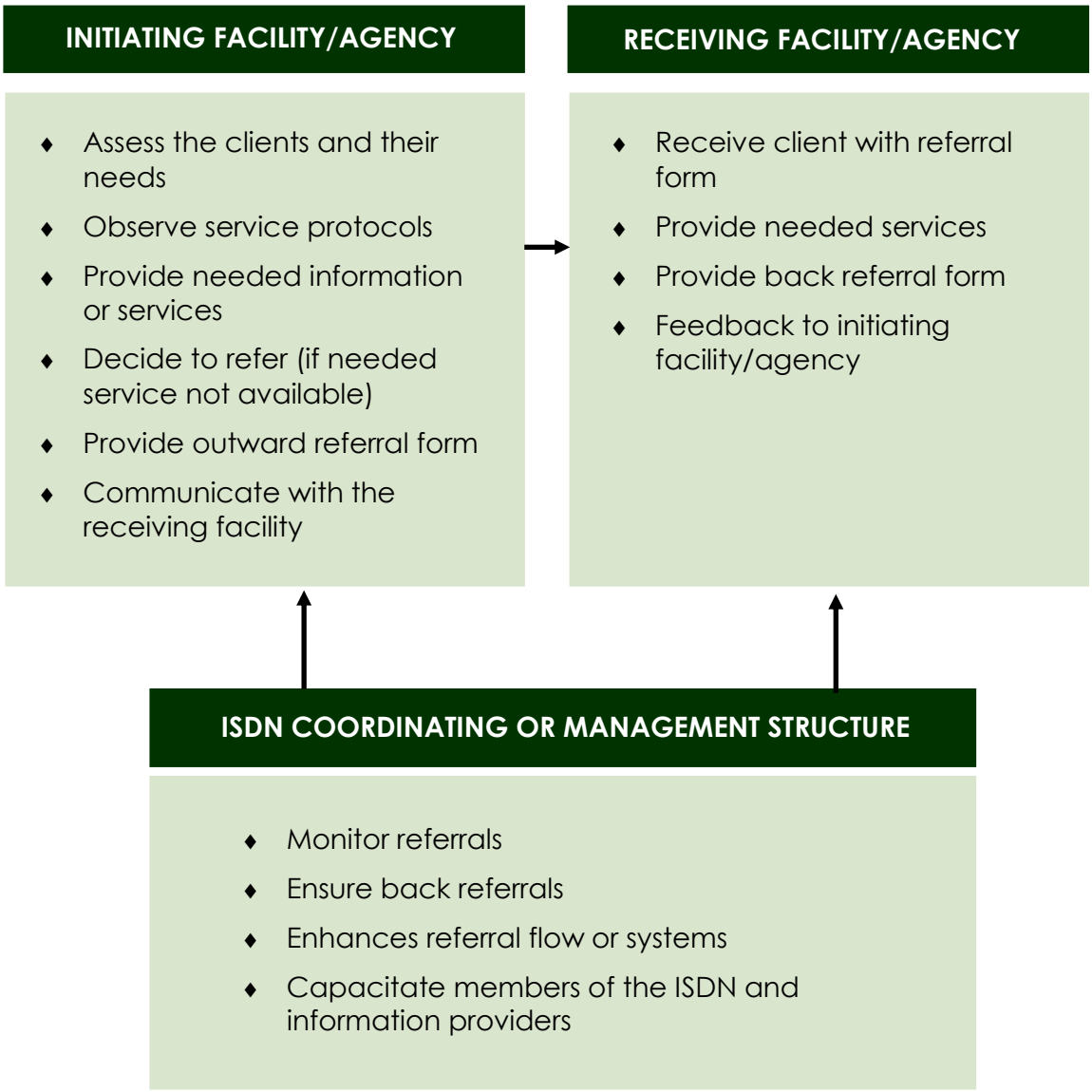
Being a ***system***, determines a referral system requires consideration of all its parts. A sample of referral flow is depicted in Figure 3. The referral system can be adjusted as relevant to the local situation.

The design and function of a referral system will be influenced by:

i. **Service delivery systems determinants** which include capabilities of facilities at lower levels; availability of specialized personnel; training capacity; organizational arrangements; cultural issues, political issues, and traditions; and

ii. **General determinants** such as population size and density; terrain and distance between urban centers; pattern and burden of disease and demand for and ability to pay for referral care.

Figure 3. Generic Referral System Flow



Coordinative Mechanism and Referral System

Some examples of referral flow can be found in Figures 4, 5 and 6. An effective referral system ensures a close linkage between participating facilities and institutions at all levels. It helps to ensure adolescents receive the best possible and accessible care and services. A good referral system can help to ensure that:

i. Clients receive optimal care at the appropriate level;
ii. Clients who most need specialist services can access them in a timely and convenient way; and
iii. The continuum of health, social, and other needed services by adolescents is ensured.

Major Components of the Referral Network

In the diagram above, the referral systems mainly consists of the initiating and receiving facilities and the ISDN Coordinative or Management Structure.

The **Initiating Facility (IF)** is the first facility from which the adolescents initially sought specific information or services. If the service sought is not available in the initiating facility, the IF starts the referral process and prepares the outward referral to communicate the condition of the client with the facility to which the client shall be referred. A sample referral form is provided in Annex F.

Figure 4. Sample AHD Referral System

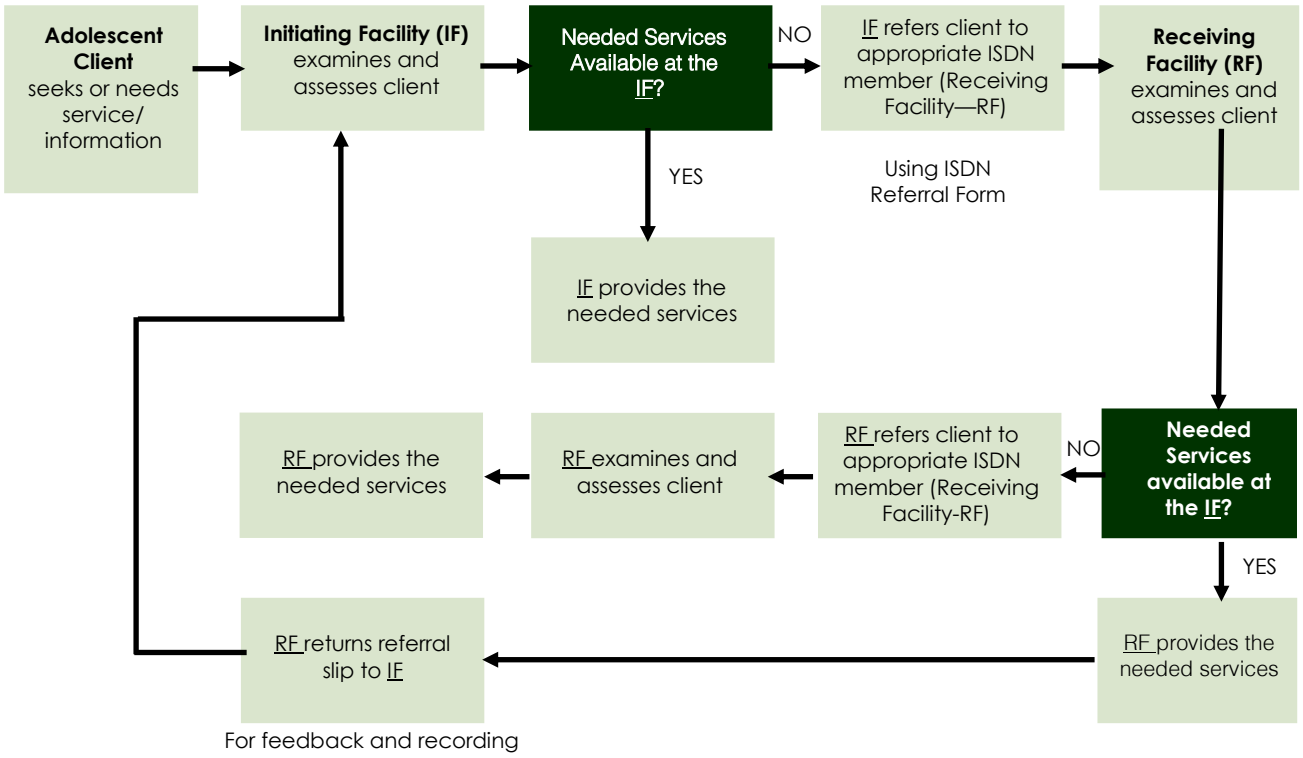


Figure 5. Sample AHD Referral System for Health Care Services

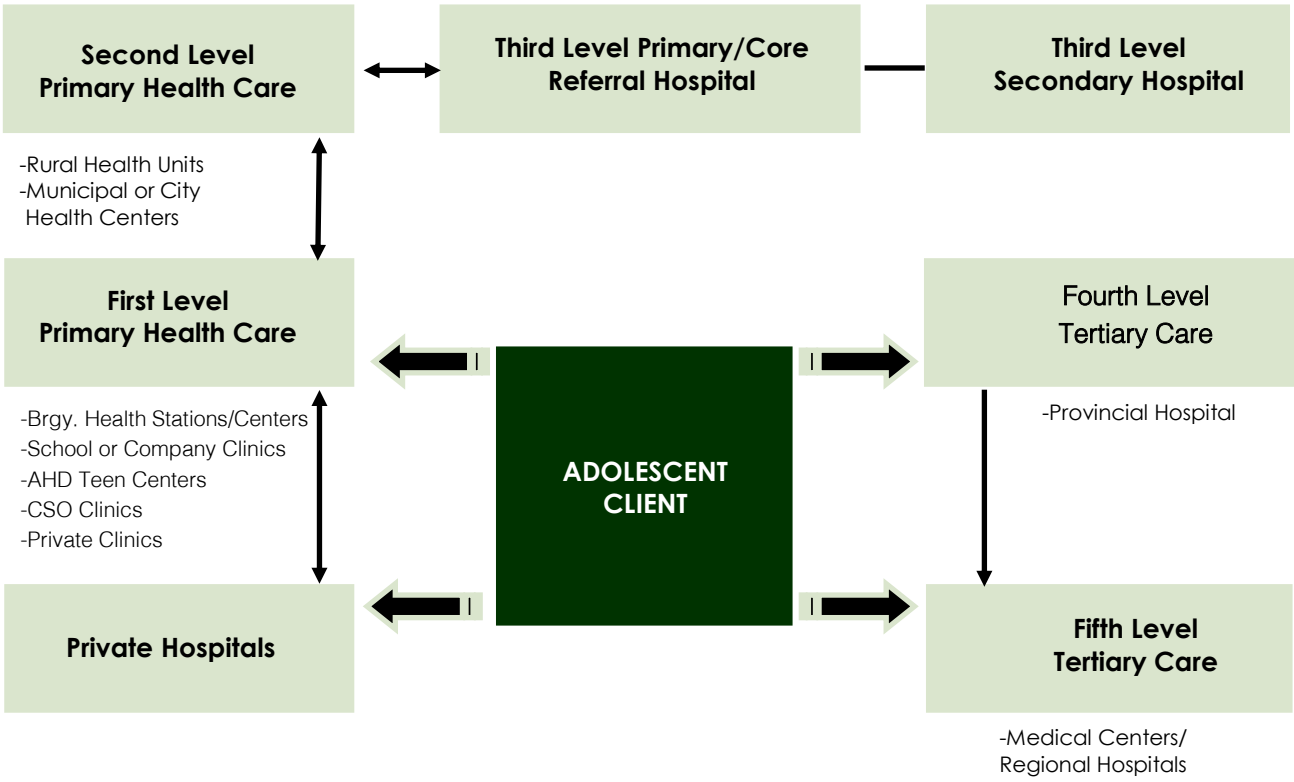
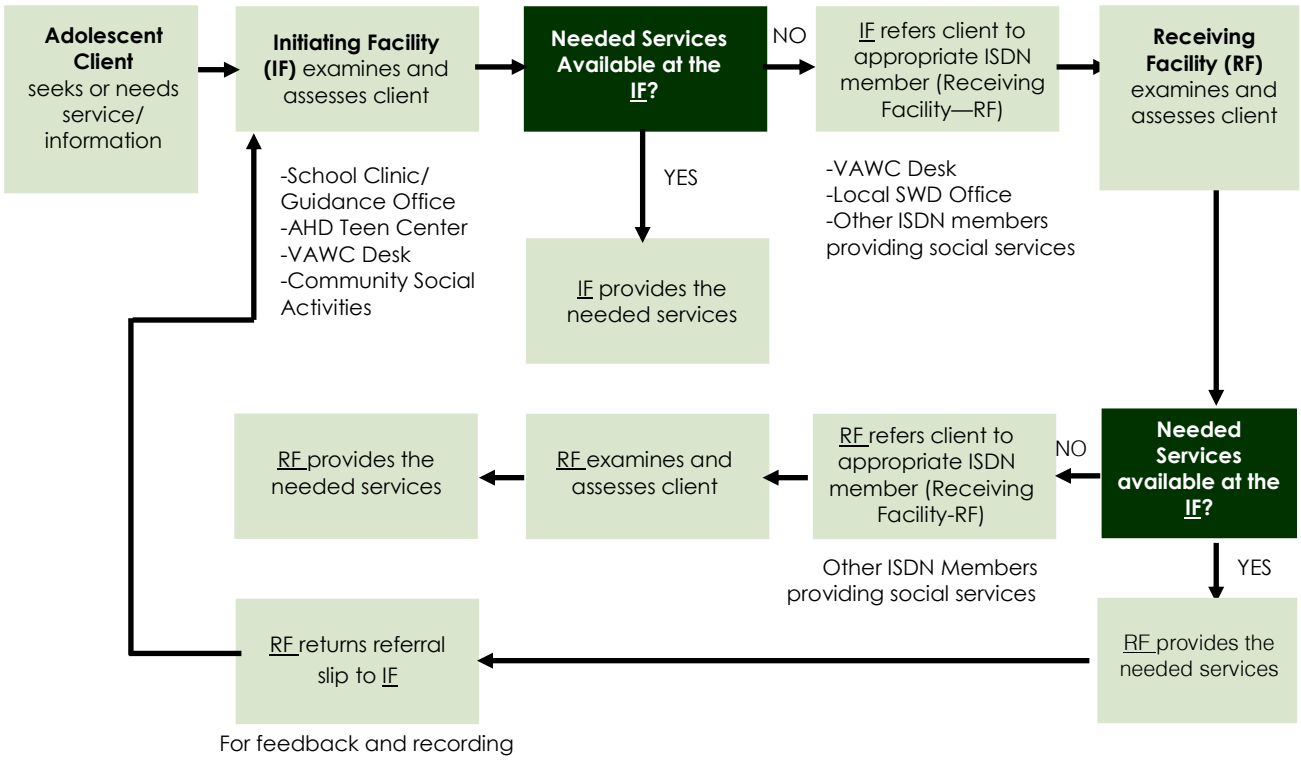


Figure 6. Sample AHD Referral System for Social Services



The receiving facility prepares and transmits **back referral** (on the lower part of the form) to the referring or initiating facility to inform them of the services provided to the clients they referred. This completes the referral loop between the two facilities.

In an actual ISDN Referral System, the members can specify in the referral flow the institutions or facilities (e.g. by name of the facility) that can be the initiating and/or the receiving facilities for specific type of information and services. The types of services by each facility can be based on the outputs from mapping of available services or during the consultation meetings. This then shall be formally agreed through a Partnership Agreement entered into by all members of the ISDN.

Referral Practicalities. A standard referral form throughout the network of service providers ensures that the same essential information is provided whenever a referral is initiated. The referral form helps facilitate communication in both directions (e.g. forward and back referral).

Every patient referred out should be accompanied by a written record of the condition of the client resulting from initial assessment, any treatment given before referral and the specific reasons for making the referral. The referral form should accompany the client (often carried by them) and give a clear designation of to which facility the patient is being sent. A carefully filled-out referral card helps the client get timely attention at the receiving facility.

Communication with the receiving facility facilitates easier access to needed services. It helps the receiving facility to prepare the needed services once the client reaches the said facility. If the client is in emergency condition, personnel from the referring facility may accompany the client to the receiving facility. The decision to refer should be properly explained to the client to lessen any fear or stress brought by the referral.

Each facility in the network should have a referral register to keep track of all the referrals made and received. Information from the register is used to monitor referral patterns and trends. A standardized referral register used throughout the network of service providers can facilitate this (Annex G).

Referral standards set and observed in various sectors such as for health care (e.g. referral standards and protocols for health service delivery network) and social services (e.g. referral standards and protocols for management of VAWC cases) be maintained for AHD referral system.

Designation of Population to the Network. In setting-up the referral system, identify the specific area that will be covered by the system.

Referral Register. Both the initiating and receiving facility must maintain a list of inward and outward referrals for one facility or service provider (see Annex G for example of AHD Referral Register). Information registered includes client referred, to where, when and why, whether the case is closed or continuing (the retuning referral form has been received with any necessary rehabilitation or follow-up), and whether it was an appropriate referral or if there were any issues.

It is important that all members of the ISDN must have a directory of all the members and other facilities within the locality that can be tapped for relevant services. Update the directory as regular as possible. An example of ISDN Directory is provided in Annex E (Sample ISDN Directory 2011).

Adolescent-Friendly Facility. It is important that in any facility or institution where the adolescent seeks information and services, they are treated with respect and ensured that their confidentiality is protected. As such, all facilities should ensure that:

- Service providers are non-judgmental and considerate in their dealings with adolescents and that they have the right competencies needed to deliver the right information and services in the right way;
- Facilities are equipped to provide the information and services the adolescent needs or if any service is not available within the facility, they are properly and timely informed and referred to other facility that can provide the needed services;
- Facilities are appealing or attractive to the adolescents and that their confidentiality is secured; and
- Adolescents are aware or informed of what, where, and how they can access specific services within or outside the facility.

ISDN Management Structure. During the organizational meeting, it is also very important to agree with participating members on a management structure that will ensure that the ISDN is efficiently functioning. An ISDN Management Committee may be organized to provide overall technical direction and guidance in the organization and day-to-day operations of the ISDN.

Specifically, the Committee shall establish appropriate management arrangements including the schedule of TWG meetings, collecting and consolidating reports on a regular basis, establishment of needed data and information base, communication protocols, and financial management.

The Committee shall be composed of the principals and senior officials or representatives of the agency members of the ISDN. The Chairperson of the Committee shall be elected from among its members and shall serve for an agreed period.

To technically and administratively assist the ISDN, designate a Secretariat. The Secretariat may be the Office that is in-charge with the implementation of adolescent or youth health and development programs (e.g. the local population office). The Secretariat functions shall be integrated in the annual work and financial plan of the designated office. It can also seek technical assistance from relevant national agencies such as the Commission on Population and Development, National Youth Commission, and Department of Health, among others.

g. Formalizing the ISDN through a Partnership Agreement. After agreeing or setting-up the referral system including the roles and responsibilities of each stakeholder within the system, formally organize or create the ISDN through a formal instrument such as Partnership Agreement or Memorandum of Understanding or Agreement (see Annex H for sample Partnership Agreement). The agreement provides the agreed terms of reference among members, the referral system, and other institutional arrangements that legally and official bind and guide all members in achieving the common objectives of the ISDN.

Discuss the draft Partnership Agreement during the first organizational meeting. Initial comments and inputs may be provided during such meeting. All members must identify and review their roles and functions in the ISDN. Provide all prospective member institutions of the ISDN shall then be provided with the draft Partnership Agreement for their further review with their principals or concerned officials/personnel. After an agreed timeframe, revise and finalize during a meeting of the members. Send back the final version of the document to the members for the signature of their principals. Conduct formal signing of the agreement through a simple public ceremony attested or witnessed by beneficiaries and other stakeholders.

h. ISDN Action Planning. During the initial organizational meeting or in succeeding meetings of the ISDN, formulate an Action Plan to provide a consolidated and organized actions or activities to be jointly or independently implemented by the members of the ISDN towards the achievement of the agreed results framework for adolescent health and development program in the locality. Indicate in the action plan the budget requirements and the sources of funding to ensure that the activities identified in the plan are to be implemented.

The steps in Action Planning may include the following:

Step 1. Develop AHD Program Results Matrix. The results matrix consists of the different expected results at the impact-outcome-output-input levels with their corresponding performance indicators. It provides the common expected results at different levels to which the members of the ISDN are to contribute. In developing the results matrix, take into consideration the priority AHD issues identified by the members of the ISDN. The results matrix will also serve as the basis for the monitoring and evaluation strategies of the ISDN. A sample results matrix for AHD program at a local government unit is provided in Annex I.

Step 2. Identify Strategies and Activities to be Implemented Jointly and Separately by the ISDN Members. Based on the AHD issues and expected results indicated in the matrix, identify specific strategies and activities to be implemented either jointly or separately by the ISDN members. Overall, the key strategies and activities should provide a consolidated view of all interventions of the members of the ISDN to ensure that all AHD issues are being addressed. Interventions may include activities that aim to improve the capacities of the ISDN members to more efficiently perform their tasks or strengthen the coordinative or collaborative mechanisms. A sample of the action plan is illustrated below in Table 3.

Step 3. Identify Needed Resources, its Possible Source, and the Responsible Institutions. To ensure that the activities will be implemented, indicate the needed budget and its source. Members of the ISDN may pool and allocate their resources on common activities to optimize the impact of such activities. Activities for building the capacities of the members of the ISDN may also be included in the consolidated action plan. Refer to Table 3 for a sample of the action plan.

i. Set the Regular ISDN Meeting. To maintain the functionality of the ISDN, set and conduct regular meetings. The meetings may be used to plan strategies and activities to be implemented under the agreed ISDN Action Plan; to address emerging concerns and issues; and to monitor and assess implementation of agreed interventions.

Table 3. Sample ISDN4AHD Consolidated Action Plan

AHD Issues	Objectives	Activities	Output	Responsible Office	Budget	Budget Source	Time Frame
ISDN Organizational Activities							
	To enable members of the ISDN to provide quality services to adolescent clients	1. ISDN4AHD Regular Coordinative Meetings	12 meetings conducted	ISDN Secretariat (Population Office)	P60,000	Population Office	Every 1st week of the month
		2. Orientation on ASRH Concepts and Issues for members of ISDN	All members of the ISDN oriented on ASRH	Population Office	P100,000	Local Health Office	February 4-5, 2019
		3. Training of ISDN Members on Comprehensive Sexuality Education (CSE)	All members of the ISDN oriented on CSE	Population Office	P100,000	Local Health Office	March 1-5, 2019
		4. Training of ISDN Members on Comprehensive Sexuality Education (CSE)	All members of the ISDN oriented on CSE	Population Office/ DepEd	P100,000	DepEd	March 1-5, 2019
		5. Training of ISDN Members on Adolescent Job Aid (AJA) for AHD	All members of the ISDN oriented on AJA	Local Health Office	P130,000	Local Health Office	April 1-5, 2019
		6. Training of ISDN Members on SHAPE, U4U Teen Trail, and Parent-Teen Talk	All members of the ISDN oriented on various AHD strategies	Population Office	P130,000	Population Office	May 1-5, 2019
		7. ISDN Midyear Planning and Assessment Meeting	Action Plan assessed and revised	Population Office	P50,000	Population Office	August (1st week)
		8. ISDN Year-end Planning and Assessment Meeting	Action Plan assessed and revised	Population Office	P50,000	Population Office	December 15-16, 2019

AHD Issues	Objectives	Activities	Output	Responsible Office	Budget	Budget Source	Time Frame
ISDN Programmatic Activities							
Increasing incidence of teenage pregnancy	To reduce % of adolescents who have begun childbearing from 20% to 5%	9. Training of School and Health Facility Service Providers on AJA	Trained 100 service providers	Local Health Office	P130,000	Local Health Office	February 20-24, 2019
		10. Training of Officers of Parents-Teachers Association (PTA) on Parent-Teen Talk	Trained all officers of PTAs	DepEd/ Population Office	P50,000	DepEd/ Population Office	March 12-13, 2019
		11. Conduct of Teen Trail in Schools	1,000 students provided with ASRH information	DepEd/ Population Office	P150,000	Population Office	June-September 2019
		12. Conduct of Parent-Teen Talk among PTA Officers	1,000 parents provided with ASRH information	DepEd/ Population Office	P150,000	Population Office	June-September 2019
		13. Life Skills Training for Adolescents	50 youth leaders trained as trainers on life skills	SK Office	P300,000	SK Fund	June 25-30, 2019
		14. Training of Peer Educators in all Schools	12 youth leaders trained as peer educators	SK Office	P500,000	SK Fund	July-August 2019
		15. Provision of Maternal Health Care for Pregnant Adolescents	105 pregnant adolescents provided with MNCHN services	District Hospital	---	District Hospital	Continuing
		16. Provision of Counseling to Adolescent Victim of VAWC	All VAWC Victims	Municipal VAWC Desk	---	Local SWD Office	Continuing
		17. Establishment of AHD Teen Centers in Selected Schools	50% of schools with Teen Center	Population Office/Schools	P500,000		Continuing

AHD Issues	Objectives	Activities	Output	Responsible Office	Budget	Budget Source	Time Frame
ISDN Programmatic Activities							
Increasing percentage of adolescents engaging in risky behaviors (i.e. alcohol and drug use)	To reduce % of adolescents who have experienced taking alcohol and illegal drugs from 40% to 10%	18. Anti-smoking and Anti-Drug Use Campaign in Schools	100% of all students provided with accurate information on the impact of alcohol and drug use	Local Health Office	P200,000	Local Health Office	June-November, 2019
		19. Conduct of U4U for Anti-smoking and anti-drug use campaign at the community level	100% of all OSYs provided with accurate information on the impact of alcohol and drug use	SK	P145,000	SK Federation	April-May 2019
		20. Provision of counseling to adolescents with family problems	100% of all adolescents seeking counseling service provided with the needed service	School guidance office/ Local Health Office		School guidance office/ Health	Continuing

SECTION 6

ESTABLISHING THE AHD TEEN CENTER

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ESTABLISHING THE AHD TEEN CENTER

WHAT IS AN AHD TEEN CENTER?

A Teen Center is an integrated, comprehensive, and one-stop-shop facility that provides appropriate information, skills, and services to adolescents and young people. Teen Centers complement and reinforce the role of schools, families, and communities in educating, counseling and empowering the adolescents. They are potent sources of information and learning aid for skills building or simply places for recreation or socialization after school hours.

The Teen Center as ISDN Convergence Facility or Service. As a client-focused facility, the Teen Center forms part of the referral system for the ISDN, either as initiating or receiving facility, especially for adolescents in distress or with concerns that require specific professional or special attention. It may serve as a convergence facility for the services of the members of the ISDN within the locality. As such, the center can be collectively managed and maintained by the members of the ISDN through their respective services. Each of the ISDN member may include the Teen Center as part of their facility where they can provide their respective services. Given this, the Teen Center pools the resources and services from the ISDN members to ensure the comprehensiveness of AHD information and services being provided in the facility. For example, the local health office may make the facility as an extension of the health center for the provision of health services for adolescents and the local social welfare office for the provision of social services, among others.

AHD Teen Centers may be based in schools or in communities. The most important consideration in setting-up the facility is its accessibility among intended clients. It should be easily accessed by adolescents.

WHY ESTABLISH AN AHD TEEN CENTER?

As studies have shown, adolescents do not usually visit health or service facilities for various reasons. They prefer accessing services in a facility where they are most welcome and served in a non-judgmental way. Being a specialized facility, Teen Centers attract adolescents with its adolescent-friendly feature and services. The facility serves as a one-stop-shop for their needs which is managed by their peers from whom they can access AHD-related information and services. This peer-to-peer approach encourages them to seek health and social services because they know that the service providers can understand and can empathize with them and that the confidentiality of information generated from them is secured.

Moreover, the center serves as a hub that does not only provide serious information and services they need but it also provides a space for their recreational and entertainment needs. It combines recreational activities with the opportunity for adolescents to access needed information and services in a friendly and fun way. This combination of recreation and serious service cannot be provided in many facilities such as health, social welfare, and employment facilities.

> **"A teen center gives teenagers a safe place to socialize and hangout and reduces the chances that they will engage in criminal behavior, according to a 2011 article published in the American Journal of Community Psychology. Teen centers also help reduce the chances that teens will engage in other risky activities, such as unprotected sex and alcohol use. Teens want certain features in their center, and when these are included, more teens will spend their free time there and less time being bored and getting into trouble." (Ipatenco, 2015)**

Purpose of an AHD Teen Center. Generally, the Teen Center aims to improve access of adolescents to AHD-related information and services through a dedicated, specialized, and accessible facility that offers a wide range of age- and development-appropriate information and services and programs for adolescents 10 to 19 years of age. Specifically, a Teen Center aspires to:

1) Engage the clients in adolescent-led initiatives and inform them of new opportunities to develop their God-given gifts, interests and skills;
2) Identify adolescent needs and wants by interacting with them and allowing them to interact with one another in a guided and controlled environment;
3) Make appropriate referrals for information, education, medical and clinical and counseling, employment, social protection schemes and programs or recreational activities based on identified individual or group needs and vulnerabilities;
4) Provide training workshops or seminars in STI and HIV/AIDS testing and teen pregnancy prevention, delaying sexual debut, alcohol and drug abuse prevention, personal hygiene, mental health development, conflict resolution, adolescent fertility management, responsible sexuality, healthy lifestyle and sexual behavior and reproductive health education;
5) Assist adolescents in formulating and realizing their future state of well-being through guided symposia, capability building fora and activities;

6) Promote a safe space and supportive learning community among adolescents where fertility management, responsible sexuality and reproductive health, effective communication, leadership and other life skills are honed, harnessed and put to good use; and
7) Establish and operate an accessible facility where the member of ISDN and other stakeholders can extend their services to be accessed more easily by adolescents.

In the long term, by improving access of adolescents to appropriate information and services, they are enabled to prevent and avoid sexual and non-sexual risky behaviors that may undermine their capacity to achieve their potentials and aspirations.

HOW TO ESTABLISH AN AHD TEEN CENTER?

1 CREATE AN INITIAL LIST OF ALL FACILITIES AND ORGANIZATIONS PROVIDING AHD INFORMATION SERVICES FOR ADOLESCENTS WITHIN THE LOCALITY

WHO:

ISDN Members: The ISDN shall take the lead in identifying and developing the types and package of services to be provided in the AHD Teen Center. Other stakeholders who are not members of the ISDN including the intended beneficiaries may also be consulted.

WHAT:

This activity aims to identify the critical and most needed services to be included in the package of information and services to be provided in the AHD Teen Center.

HOW:

1. **Review the key issues and needs of adolescents in the locality.** Based on the outputs of the previous activities conducted in relation to the establishment of the ISDN (Section 3 and 4), review the key issues of adolescents that need specific type of interventions or services. From among these issues, identify concerns that can be addressed with specific services that can be offered in AHD Teen Centers.

2. **Review the available services within the locality.** Similar to actions taken in the establishment of the ISDN (e.g Section 4), map the available AHD services and interventions in various facilities and institutions in the locality to determine the gaps in the services that can be addressed by the AHD Teen Center.

3. **Identify specific services and interventions that can be offered in the Teen Center.** Based on the analysis of the needs and issues of the adolescents and the available AHD services within the locality, identify the specific type of services that will be provided in the Teen Center. The package of priority information and services to be offered in the Teen Center may focus on any or a combination of the following: information, referral, counseling, medical and clinical services, training, mentoring, and recreation.

Some of the major services that the Teen Center can provide include the following:

a. *For health care services:*

- Access and referral to primary and preventative health care services;
- Diagnostic services (e.g. HIV/AIDS testing, pre- and post-natal check-up, pregnancy testing);
- Family involvement in adolescent reproductive health and rights;
- Health and well-being development;
- Dental services;
- Proper hygiene services;
- Teen pregnancy and STI and HIV/AIDS prevention programs;
- Mental health services (e.g. psychological counseling);
- Comprehensive sexuality and reproductive health education; and
- Primary health education and campaign (e.g. proper nutrition, anti-smoking, anti-drug use, etc.).

b. *For Personal and Psycho-social well-being and Development:*

- Socio-emotional skills improvement;
- Peer and guidance counseling services or referral to professional counselors;
- Coaching and mentoring on life skills and achieving developmental tasks; and
- Recreational and development of multiple skills and talents (e.g. sports and talent competitions).

c. *For Education Services:*

- Learning and academic support services (e.g. tutoring and group learning activities);
- Referral for scholarship and training; and
- Computer and internet services.

d. For Employment:

- training on technical and vocational skills; and
- employment referral and assistance.

e. For Community Participation and Involvement and General Services:

- referral to basic community-based services; and
- involvement and mobilization of adolescents in community-based or outreach activities or projects (e.g. environmental clean-up drive; charity works; etc.).

In the design of the various services to be offered in the Teen Center, consider the availability of resources to include expertise, personnel, funding, equipment and other inputs to operationalize the center.

2 GATHER AND CONSOLIDATE INSTITUTIONAL AND POLICY SUPPORT FOR THE ESTABLISHMENT OF THE TEEN CENTER

WHO:

ISDN Members. The ISDN shall take the lead in consulting stakeholders and consolidating needed support for the establishment of the AHD Teen Center. This is in collaboration with key stakeholders including the concerned schools and communities where the Teen Centers will be set-up and operationalized. Stakeholders may include the members of the ISDN, local chief executives and other concerned local officials, school officials, *Sangguniang Kabataan* (SK) officials, barangay officials or community leaders, and relevant civil society organizations with the locality.

WHAT:

This activity aims to gather and mobilize institutional support needed for the establishment of the facility. It aims to generate concrete support such as policy, institutional commitments, and resources, among others, from stakeholders within the locality.

HOW:

Consult Stakeholders. As an ISDN group, collaborate with the key officials at the local government unit and from regional government agencies (e.g. POPCOM, DSWD, DOH, DepEd, etc.), SK officials, school officials, community or barangay officials, civil society organizations (CSOs) or non-government organizations (NGOs), and other relevant institutions that could support the establishment of the teen center.

3 DESIGN AND OPERATIONALIZE THE AHD TEEN CENTER

WHO:

The ISDN shall take the lead in designing the teen center in close collaboration with the key stakeholders identified above.

WHAT:

This activity aims to finalize the mechanism or structure of the teen center including operational and programmatic designs.

HOW:

1. **Finalize Operational, Physical, and Programmatic Design of the AHD Teen Center.** In designing the AHD Teen Center, identify the following key concerns:

a. Programmatic Concerns:

- What are the key issues and specific program objectives that the teen center aims to address or achieve?
- What specific information and services can be accessed in the facility?
- What are the specific activities and projects to be conducted in the facility including capacity building for staff and clients, communication strategies such as seminars, fora, symposiums, IEC materials development and dissemination, peer education, counseling, and other activities that aims to provide accurate information?
- Who are the target audiences and beneficiaries?
- Who shall implement these strategies? Who are the partners in conducting these activities?
- How much resources are needed and where to source them out?

b. Operational and Physical Concerns:

- Who shall be involved in the management of the facility? Who are the service providers to provide the services?
- Will the staff serve in full-time, part-time, volunteer, or paid basis?
- What are their roles and functions?

- What time can the facility be accessed?
- Where will the facility be located?
- Who can access the facility?
- Are the services for free or with minimal payment?
- How are the services in the facility accessed? What are the service protocols?
- What is the design of the facility to make it adolescent-friendly?
- How will the operation of the facility be sustained?

Write the design of the Teen Center in a concept note for appreciation of the stakeholders and proper documentation. **The essential components and characteristics of adolescent-friendly teen centers are discussed in Table 4. These are also critical guides in setting-up the facility.**

Table 4. Essential Components and Characteristics of Adolescent-Friendly Teen Centers

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
• Effective leadership and management	• The enabling environment for the establishment of the center is facilitated by strong support from key decision-makers and stakeholders • The commitments of local officials are expressed and concretized by policy issuances and allocation of corresponding resources	• Conduct advocacy initiatives for decision makers to generate support for the establishment of the center • Advocate for the issuance of corresponding policy to ensure allocation of resources and sustainability • Foster a consultative process with stakeholders including the members of the ISDN to foster owner-ship and collaboration • Document commitment through partnership agreements or memorandum circular (e.g. this can be integrated in the institutional agreement between ISDN members)

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
• Physical Characteristics	• Systems in the facility are implemented to ensure that adolescents are knowledgeable about their health and development needs and how to access the services	• Put a signboard in the facility that informs the public about the type of services accessible in the facility, time of operation, and protocols • Conduct promotional activities to inform adolescents on the availability of AHD services in the teen center
	• The Teen Center facility bears dual purpose in the sense that it accommodates both unstructured social interaction sessions among different or the same teenage groups and structured knowledge, skills and attitude building or training workshops in a supervised and controlled condition	• Depending on the available floor area, design and arrange facility layout and proxemics of the rooms into efficient space utilization for the fulfillment of formal gatherings and informal ones • Based on Figure 7 (Basic Layout and Proxemics of a Teen Center) below, the facility may have a space for receiving area, multimedia space, counseling room, and multi-purpose space
	• The health facility has convenient operating hours and an adolescent-friendly environment that maintains privacy and confidentiality	• As the heart of the Teen Center, the Counseling Room promotes privacy and confidentiality – visually and auditory • A multimedia space may provide the clients with supervised internet access for homework purposes and guided multimedia experience (e.g. film viewing, arts and music jam-ming, etc.) only

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
		• Design entrances and exits to and from the other rooms in a way that facilitates access even when the rest of the rooms or spaces are closed or being used • If the area only allows for a large multipurpose space, design the overall proxemics to meet maximum utility and flexibility through the use of flexible dividers • Create a 'homey' feeling inside the Teen Center facility while meeting the requirements for a multipurpose facility • Provide ample natural light and indirect ambient lighting, a welcoming entrance and a control desk for client record database and administrative responsibilities • Extend operating hours if necessary, allow walk-in appointments, and ensure youth-friendly amenities in the waiting room (e.g., magazines, internet access, brochures) • Design the interior makeup, color and texture of the facility in a way that is attuned to the clients' cool lifestyle

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
		• Communicate a sense of enjoyment and celebration while learning through murals or mounted artworks and visual aids and by announcing future tasks and/or activities in a fun way • Encourage autonomy from peer educators and facilitators but provide space to help adult staff in developing and maintaining the Teen Center administrative functions and official businesses • Locate the facility in accessible area
• Community and stakeholders support and ownership	• Parents, guardians, and other community members recognize the value of adolescent health and development services	• Providers educate parents, teachers, and other community organizations about the value of adolescent health services • Conduct policy advocacy for the sustainable operation of Teen Center • Create a network of caring leaders and responsible adults (e.g. trained guidance counselors and advocates, teachers, nurses, community workers, volunteer parents, etc.) with the passion and willingness to work with teenagers while ably supported by trained peer educators and facilitators, enthusiastic community leaders and gatekeepers and service delivery network provided by concerned NGOs, GOs, POs, NGAs and other stakeholders

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
		• Promote community outreach activities in partnership with the LGU, academe, Sangguniang Kabataan (SK), CSO, Government Agencies, NGOs and various donor and development agencies in Geographically Isolated and Disadvantaged Area (GIDA) • Involve all the beneficiaries (i.e. adolescents, youth leaders, peer educators, parents, village officials, etc.) from the planning phase to the evaluation phase to gain their approval and to establish a sense of ownership for the maintenance and continued operation of the Teen Center
• Comprehensive and appropriate package of health and socio-economic services and information	• The facility provides a package of information, counseling, diagnostic, treatment and care services that fulfills the needs of all adolescents (see Step 1 above)	• Policies are in place that define the required package of evidence-based clinical preventive services
	• Services are provided in the facility and through referral linkages and outreach	• Ensure that all institutional members of the ISDN commit to provide extended services in the facility • Establish feedback mechanisms to identify emerging needs of adolescent clients • Ensure the mapping of available services and consultation with key stakeholders especially those that can participate in the provision of needed services in the teen center

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
		• Complement the adolescent-responsive reproductive health care services provided by the LGU in Rural Health Units (RHU), Barangay Health Stations (BHS) and government-run hospitals and service delivery facilities within the locality where the teen center is located • Link the activities of the Teen Center with Population and Development Education (PopDevEd) or Comprehensive Sexuality Education (CSE) programs in schools and communities to foster an integrated human sexuality and population education • Make available printed or electronic/ digital materials on AHD for take-home information
• Service providers' and other teen center staff's skills and competencies	• Teen center service providers and staff demonstrate the technical competence required to provide effective health and development services to adolescents (e.g. confidentiality, respect, and non-discrimination)	• Assess and map needed competencies of technical and administrative staff of the teen center • Continuously provide training and capacity building activities for the staff and service providers on providing sensitive health and development services to adolescents • Hold capacity building exercises and workshops for peer educators, facilitators and adult moderators to ensure

Components	Key Characteristics/ Attributes	Specific Strategies and Actions to be Taken
		the provision of developmentally-appropriate (e.g. age, individual and culture appropriate), accurate and timely information, education, communication and counseling and referral services • Put in place job aids and support tools (e.g. protocols, guidelines) for providers and staff of the teen centers to enable them to provide quality services • Establish mentoring and post-training supervision and monitoring and skills assessment to ensure appropriate application of skills and competencies
• Equity and non-discrimination	• Adolescents are provided quality services regardless of income, age, sex, marital status, education, race/ ethnicity, sexual orientation, or other characteristics	• Design and implement policies and procedures to ensure equitable care for all young people, services are offered at more affordable rates, providers and staff are trained on providing sensitive services to vulnerable groups of adolescents

Figure 7. Basic Layout and Proxemics of AHD Teen Center

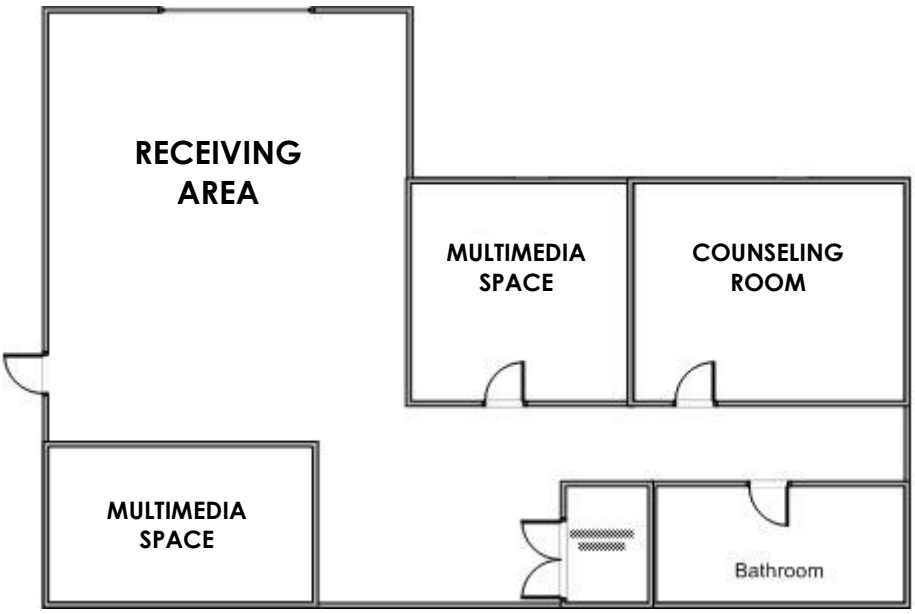
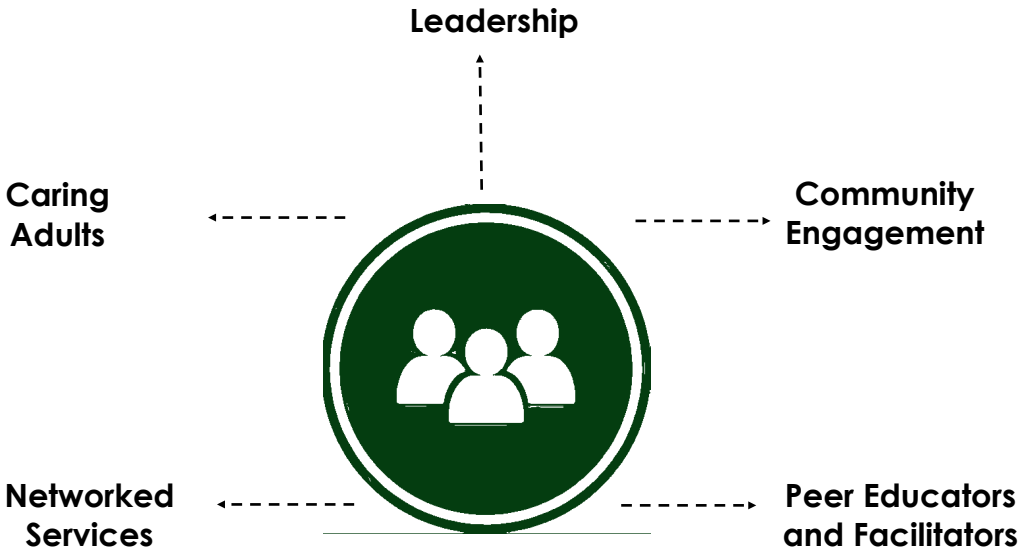


Figure 8. Network of Critical Stakeholders for Establishing and Sustaining AHD Teen Center



2. **Publicly Open and Operationalize the AHD Teen Center.** Based on the design of the Teen Center, open the facility to the intended users for them to access available services. Conduct promotional activities such as a launching or drumbeating of its opening to inform the entire community. It is important that the community and the intended beneficiaries are aware of the existence of the facility as well as the available services so they can patronize or access it. The following are the key activities in operationalizing the facility:

Pre-operational activities

- Completion of the physical exterior and interior design of the facility;
- Procurement of office or facility supplies, materials, equipment, and fixtures;
- Posting of signages outside and inside the facility;
- Printing of promotional materials;
- Training of staff who will manage the facility on relevant skills and competencies;
- Development of immediate and long-term action plan (with corresponding budget requirements); and
- Securing of budget and resource requirements.

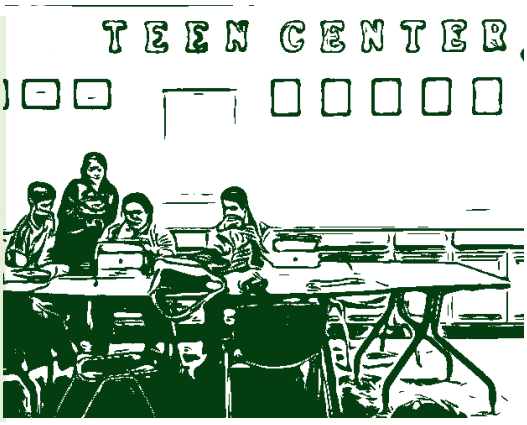
Actual Operation

- Implementation of protocols for accessing the services;
- Continuing provision of services based on the essential characteristics mentioned in Table 4;
- Continuous recording of services rendered and addressing of emerging concerns; and
- Regular monitoring and assessment of the quality of services being provided.

For actual sample of activities in the operationalization of AHD Teen Center, refer to Box A below.

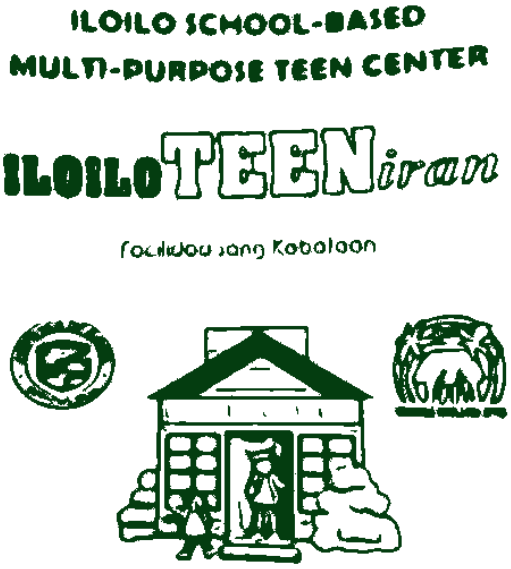
BOX A | Operation of the School-Based Teen Center (Based on Documented Experience)

The School-Based Teen Center or SBTC offers both unstructured and structured programs and activities for Grades 5 to 12 learners in an integrated school, Grades 7-12 learners for integrated secondary school and Grades 7-10 learners for basic secondary school free of charge.



The SBTC services and events are available for three (3) separate age groups: 10 to 12, 13 to 15 and 16 to 19. Teens won't spend time in a SBTC if there is nothing for them to do there. As such, teens want entertainment and recreation after or before classes start.

That is why most SBTC have at least one television set as well as a selection of age-appropriate movies (e.g. *Crossroads,* AHD Film Festival entries, etc.) for guided viewing. The SBTC may also keep a collection of board games and puzzles, books and IEC materials on adolescent sexual and reproductive health.



Most teens enjoy activities geared towards the arts. Hence, some SBTC keep paper and drawing materials as well as other arts and crafts supplies such as molding clays, crayons, water colors, plastic cups, ice drop sticks, bottle caps, etc. for more elaborate artworks. Learners may also be encouraged to engage in instrument ensemble, vocal ensemble, group dancing, improvisational theater, puppetry or shadow play as means of expressing themselves. Interacting with their friends after school is also a way of de-stressing for most teens.

Hence, SBTC may implement structured plays, games or sports activities into their operation. The equipment for these should be made available to enable them to play and have regular exercise. Jump ropes, hoola-hoops, Chinese garters, badminton, volleyball and pingpong rackets and tables are strongly suggested in the SBTC.

An important component of a successful SBTC is a place for teens to simply sit down and relax, listen to music and spend time pursuing quiet moments. This area allows teens to talk to each other or have private conversations with caring adults or staff in the SBTC.

The structured activities are usually offered on weekdays after classes and may include:

- Movie Mondays - e.g. "Crossroads", winning AHD Film Fest entries, etc.
- Tasky Tuesdays - e.g. tree planting, gardening, "Help-a-Friend Day", etc.
- Wacky Wednesdays - e.g. joke time, freedom wall writing, picture taking, "Face-Off Day", etc.
- Triumphant Thursdays – e.g. celebrating winning moments, birthdays, achievements, etc.
- Freedom Fridays – e.g. creative writing, poetry reading, demonstration of multiple intelligences, etc.

Other structured activities may include:

- U4U teen trail or teen chat facilitators' workshop or further training;
- personality development and sexuality education;
- community service projects (e.g. coastal cleanup, mangrove planting, etc.);
- social events (e.g. tournaments, field trips, etc.);
- games and amusement activities;
- leadership skills development; and
- life skills and life planning training.

Learners can also sign up for activity series along the following themes:

- baking, cooking or basic food handling;
- volleyball, badminton, pingpong or basketball;
- basic drawing, photography or filmmaking;
- vocal or instrument ensemble or visual and installation arts;
- creative writing, campus news writing, cartooning or broadcasting;
- shirt-printing, photoshop/adobe skills; and
- improvisational drama, street theater, puppetry or shadow play.

Schedule of Operation. A Teen Center typically offers 26-30 hours per week of operation. The Teen Center observes local and national holidays as well. Hours and program schedules are subject to change but the adult staff makes every effort to keep each client informed by maintaining an announcement board. During long breaks (i.e. summer break, Christmas, semestral breaks, etc.) special Teen Center activities are arranged (e.g. parent-child barbecue night or camp out, U4U, educational field trip, sports tournament, parent education on adolescent sexuality and reproductive health or Learning Package on Parent Education and Adolescent Health and Development (LPPEAHD), etc.).

Promotion. In June of every school year, an orientation is conducted to promote the SBTC and its services to all learners and their parents. It is conducted during the school orientation program or simply by having peer educators hold room-to-room campaign sorties to familiarize the learners with the SBTC. If possible, involve the whole school community in promoting the SBTC by enlisting the participation of the alumni, security guards, maintenance personnel and non-teaching staff during the promotion period. This will help ensure that all the members of the school community (aside from the school head and teachers) are fully informed about the SBTC and its services and all are able to close ranks for the good of the learners.

KEY RESPONSIBILITIES

RESPONSIBILITIES OF TEEN CENTER USERS

The list of responsibilities below guides participant behavior at the Teen Center. Parents should promote cooperation and agreement between the home and the Teen Center to develop good citizenship and high standards of behavior among adolescents especially those helping out as peer educators or facilitators and adolescents availing the Teen Center services. Teen Center users have the responsibilities to:

1. Abide by the Teen Center Code of Conduct and protocol at all times while at the Teen Center or during a Teen Center-sponsored activity;
2. Ask a staff member for permission before entering and leaving the Teen Center;
3. Be courteous and respectful of adults and peers at all times;
4. Be supervised by trained guidance counselor or teacher moderator; trained community youth workers or volunteers or peer educators;
5. Participate in all Teen Center activities in a safe and supportive environment;
6. Show respect for Teen Center property and personal property of others availing of the Teen Center; and
7. Utilize the Teen Center computer or AV equipment for homework purposes only.

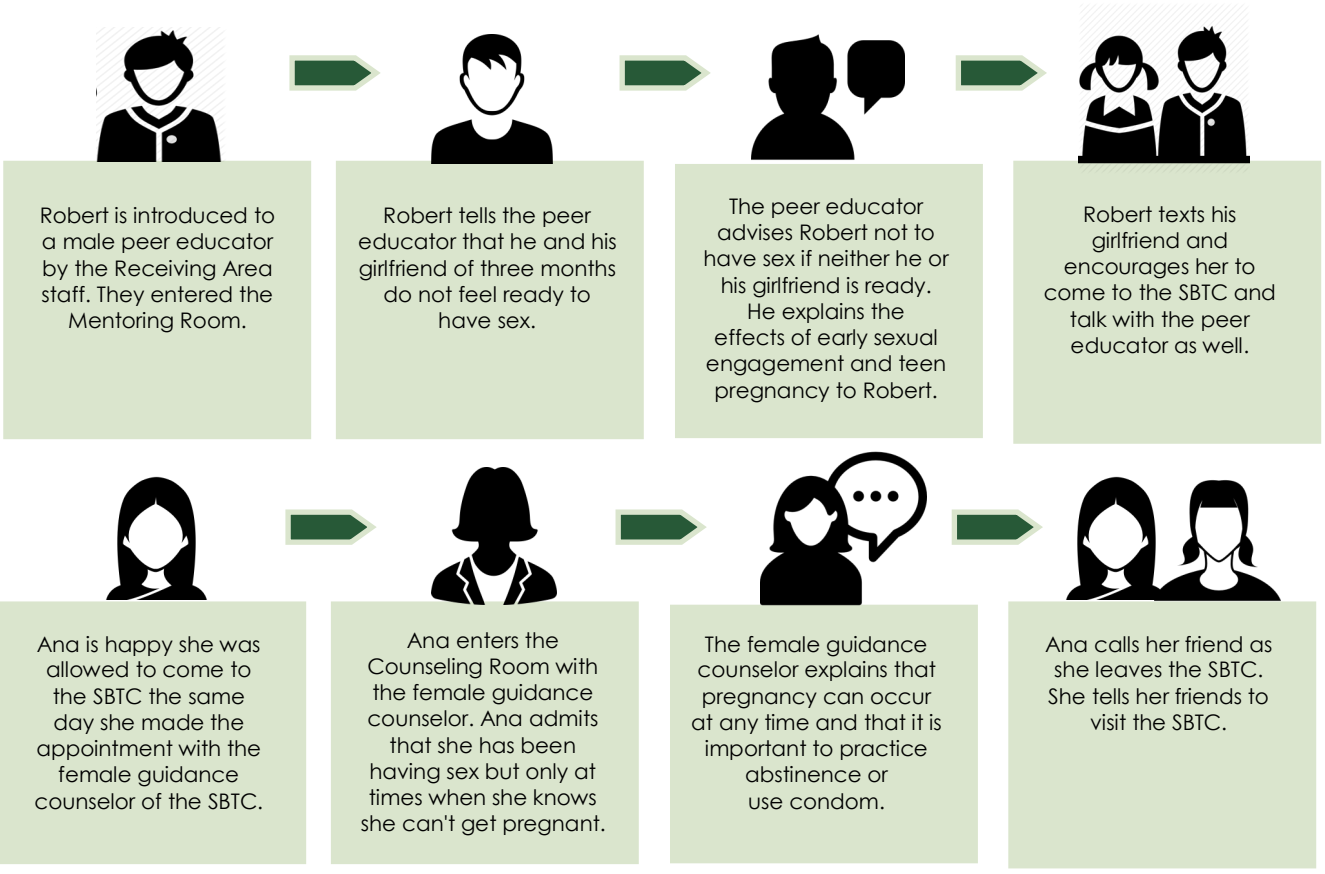
RESPONSIBILITIES OF TEEN COORDINATOR

1. Manage record keeping, database and reporting relative the Teen Center clients, programs and services;
2. Network with stakeholders and partners to enhance the services provided by the Teen Center;
3. Participate in meetings related to Teen Center operation and inform the Immediate Supervisor of progress and/or changes to the Teen Center programs and goals;
4. Participate in output-based monitoring and evaluation processes;
5. Plan and implement the Teen Center activities in accordance with established standards.
6. Use multimedia and social network to promote the Teen Center programs and encourage regular participation of peer educators and peer advocates; and
7. Perform other tasks that may be assigned from time to time by the Immediate Supervisor.

RESPONSIBILITIES OF PEER EDUCATORS

The Peer Educators are the lifelines of the Teen Center. He or she assists the Teen Center Coordinator in the overall day-to-day operation of the programs on agreed upon days and times after school hours. The Peer Educators ensure a high level of teen participation in adolescent sexual and reproductive health and development programs in a positive way and participate actively in the planning, implementing, monitoring and evaluation of programs and services. They are under the direct supervision of the Teen Center Coordinator.

THE TEEN CENTER VISIT PROCESS FLOW



3. Strengthen Peer Education as a key strategy and service of the AHD Teen Center. Various researches showed that people are more likely to listen and change their attitudes and behaviors if they believe the messenger is similar to them and are experiencing the same concerns and pressures. This communication phenomenon is likewise applicable among adolescents who give significant weight to peer influence in their decision-making processes. As such, Peer Education as an internationally implemented strategy for promoting healthy behaviors among adolescents draws on the credibility that adolescents have with their peers. As an approach, it also leverages the power of role modeling, and provides flexibility in meeting the diverse needs of adolescents through their peers.

Peer Education is an approach in promoting heathy and positive behaviors among adolescents through their peers. It is a peer-to-peer approach that provides adolescents with age and development-appropriate information, values and behavior in educating others who may share similar social backgrounds or life experiences. It aims to assist adolescents in developing the knowledge, attitudes, and skills that are necessary for positive behavior modification through the establishment of accessible and inexpensive preventive and psychosocial support. Peer education programs mainly focus on harm reduction information, prevention, and early intervention.

Who is a Peer?

- A person that belongs to the same social group as another person or group;
- A friend who has a similar background such as profession, age and language, lives in the same geographical area, has similar social status, etc.; and
- Someone who can integrate oneself.

TIPS FOR BUILDING A SUCCESSFUL PEER EDUCATION COMPONENT OF AHD PROGRAM

(Accessed through https://**www.unicef.org**/lifeskills/index_12078.htm)

- Link the peer education program (content and methods) with other AHD programs to form a comprehensive strategy;
- Ensure that a quality control process is in place;
- Ensure that a trained adult or teacher facilitates and supports the peer educators; and
- Evaluate the results of using peer educators, including:

  ⇒ Monitoring the activities of the peers (process evaluation), for example: progress reports submitted by the peer educators on number of people expected compared to reached, who they were and what was discussed; and satisfaction surveys; as well as

  ⇒ Measuring the impact of the education (outcome evaluation), for example: looking at HIV-related knowledge, attitudes, skills and behaviors, and/or health outcomes such as STI incidence;

- Consider incentives for peer educators to attract and maintain their participation. For example, recognize their contribution through: public recognition, certificates, programme T-shirts, food, money/credit stipends, or scholarships;
- Establish criteria for the skills and qualities that peer educators should have, and then have students volunteer or nominate others for the peer educators;
- Have clear and achievable expectations for the peer educators;
- Provide thorough training and regular follow-up workshops and practice sessions (this is particularly important as turnover of peer educators can be high);
- Be flexible when scheduling training and feedback sessions to maximize participation;

- Monitor and assess the needs of the trainers and educators;
- Involve young people as active participants in the project planning, implementation, and assessment;
- Make sure adequate supply of educational materials and condoms are available;
- Consider the different needs of male and female educators (for example, there may be different social expectations about how girls should behave and what they should talk about in public);
- Prepare the peer educators for community resistance and public criticism, should it arise; at the same time, inform and involve the community in the program, to alleviate any fears and to garner their support (e.g. the mothers and fathers of the peer educators, grand-parents, aunts and uncles, religious leaders, community advisory committees, etc.); and
- Ensure that mechanisms are in place to replenish the supply of peer educators (who will get older and mature out of the program).

PEER EDUCATORS

Peer educators are usually persons who have the same age or slightly older than the group or persons with whom they are working. They may work with adults such as teachers or organizations or may implement educational activities on their own. They help raise awareness, provide accurate information, and help their classmates develop skills to change behavior through various communication strategies and methodologies such as:

- informal discussions or sharing with groups of adolescents;
- video and drama presentations;
- one-on-one time talking with fellow students;
- handing out IEC materials; and
- offering counseling, support and referral to services.

Who can be Peer Educators? Those adolescents or youth who have:

- ability to multitask and be flexible;
- ability to use the computer and computer applications e.g. email, MS Office, varied social media sites, other platforms, etc.);
- ability to work collaboratively and harmoniously with diverse adolescent groups;
- ability to work towards the attainment of positive and agreed upon outputs and outcomes;
- proven active involvement in adolescent development organizations within the school or community;
- excellent academic, planning, organizational and peer-oriented skills;
- familiarity with the stages of adolescent health and development;
- emphatic leadership skills with excellent written and verbal interpersonal communication skills; and
- willingness and commitment to be trained then serve in adolescent sexual and reproductive health issues and concerns.

4 MONITOR AND EVALUATE THE QUALITY OF SERVICE AND PERFORMANCE IN TEEN CENTER

WHO:

Teen Center Managers and Workers: The staff in the Teen Center shall take the lead in monitoring and evaluating the quality of services and other agreed performance indicators for the operations of the Teen Centers. They may also involve other stakeholders such as clients and other partners in monitoring and evaluating the Teen Center programs and activities.

WHAT:

This activity aims to gather information needed for the continual improvement of the operations of the Teen Centers.

HOW:

1. Design M&E Framework or Indicator System. The monitoring and evaluation of Teen Center provides information and justification on the efficacy of the program. When knowledge collected is integrated and communicated with LGU health offices, the program impact is immense (reported in 2016 in a study entitled "*Assessment of Adolescent and Youth Reproductive Health in the Philippines*" and conducted by Pilar Ramos Jimenez, Eden R. Divinagracia, Jesusa M. Marco, Jose Narciso Sescon, John Ryan A. Buenaventura, Sucelle Czarina M. Deacosta, Gerlita C. Enrera, and Mellanie C. Yubia).

To guide the M&E activities for the teen centers, prepare a monitoring and evaluation plan which contains the indicators to be monitored and evaluated, data gathering methodologies, activities, sources of information or respondents, means of verifications, schedule of activities, and resources needed (e.g. funding and human resource).

OUTPUT INDICATORS	DATA SOURCE/S
No. of adolescents referred for expert services	Referral System Log
No. of adolescents provided with information	Visitors Logbook; Training Logbook
No. of adolescents provided counseling	Guidance Counselor Database
No. of peer educators trained	Peer Educators Training Logbook
No. of adult staff trained in Adolescent Job Aid (AJA), U4U, Interpersonal Communication (IPC), Adolescent Sexuality and Reproductive Health (ASRH), Gender-Based Violence (GBV), New SHAPE Adolescents Toolkit, LPPEAHD, Parent-Teen Talk , ASRH Module, etc.	Adult Training Logbook

2. Gather monitoring and evaluation data. Generate M&E data and information through the following methodologies:

a. Focus group discussions (FGD);
b. In-depth interviews;
c. Exit interviews;
d. Pre- and post-tests questionnaires or other structured instruments to measure change in knowledge, attitude, and skills;
e. Post-activity assessments;
f. Financial reporting;
g. Process documentation; and
h. Accomplishment reporting

3. Consolidate, process, and analyze the M&E data and information. Encode and process the M&E data gathered in an electronic or manual format. Analyze and package the data and information for discussion with the Teen Center management and staff and other key stakeholders. Through analysis, identify what strategies are working effectively and what areas needs some interventions.

4. Disseminate and use M&E results for continual improvement of the services in the Teen Center. Utilize the data for the identification and implementation of needed interventions to improve the processes and services in the Teen Center. Involve key stakeholders in the assessment as well as designing of needed interventions for continual improvement. M&E data and information may be used in the following:

a. Regular meeting of the Teen Center staff and managers;
b. Regular meeting and planning of the ISDN members;
c. Stakeholders consultation meetings and workshops;
d. Advocacy activities including meetings with key local officials;
e. Inter-agency meetings at the provincial or regional levels; and
f. Other venues where data can be used as inputs for the development of AHD interventions.

SECTION 7

PROMOTING THE ISDN AND AHD TEEN CENTER

SECTION 7

PROMOTING THE ISDN AND AHD TEEN CENTER

Access to the information and services within the ISDN and the Teen Center can be facilitated by high level of awareness of the intended beneficiaries on the existence and type of services available within the service delivery network and covered facilities. These can be done in collaboration with stakeholders within the locality through effective promotional activities. For this purpose, the ISDN can develop a promotional plan that can be jointly implemented by the member institutions.

HOW TO PROMOTE THE AHD SERVICES OFFERED AT THE FACILITIES OF THE ISDN MEMBERS AT THE TEEN CENTER?

Promotional activities aim to build the awareness of the support community and the intended audience on the availability and procedures for accessing AHD services within the facilities covered by the ISDN including the Teen Centers. As such, organize the members of the ISDN to plan and implement continuing promotional activities for the AHD services within the locality. Mobilizing the members of the ISDN ensures a well collaborated initiative in promoting AHD services especially among intended beneficiaries. It also ensures sharing of resources and competencies among the members. Table 5 provides a sample template for the planning of promotional activities.

Table 5. Template for Action Plan for Promotional Activities

Promotional Activities	Target Audience	Time frame	Budget Requirement	Other Needed Resources	Lead Office/ Agency
Example:					
1. Launching of the ISDN4AHD • Motorcade • Distribution of brochures • Distribution of directory of ISDN facilities	• High School students • OSYs in the barangays	Jan 15	P100,000	• ISDN Brochures • AHD promo-tional materials • Directory of ISDN Facilities	Population Office

Some of the effective promotional strategies that can be undertaken by the ISDN include the following:

1. **Launching Program for the ISDN4AHD and the AHD Teen Centers.** The launching activity aims to drumbeat the entire initiatives of the ISDN particularly on the available services in covered facilities including the teen centers. The launching may be done through a community program to be attended by all stakeholders including adolescents and youth.

A festive mode for the launching is encouraged to make it more attractive to the adolescents.

The launching may consist of the following key activities, among others:

- Motorcade with distribution of flyers and public announcement about the ISDN and AHD services available in specific facilities;
- A simple program for the delivery of messages from personalities including advocates among local officials, partner agencies, private sector representatives, and popular personalities who can encourage adolescents to access the services;
- Live streaming or posting of AHD messages and materials in the social media;
- Symposium, forum, or activities that can provide AHD messages to participating adolescents;
- Community radio or TV spots featuring the launching; and
- Other creative and innovative activities identified by the ISDN members.

2. **Continuing distribution or dissemination of promotional materials in the community and social media**. Conduct continuing distribution of IEC materials containing information on the available services within the participating ISDN facility or the teen centers. Distribute the materials through interpersonal communication interventions such as mobilization of adolescent leaders in the distribution of materials in areas where young adolescents usually congregate such as computer houses, *tambayans*, malls, schools, and other places frequented by young people. Distribute also through the social media platforms to reach to virtually wired adolescents. Include in the IEC materials a directory of the ISDN facilities to properly guide adolescent clients in accessing such facilities.

3. **Designate a special date or time for adolescents in health and other social facilities.** A special schedule for adolescents in accessing health and other social services within specific ISDN facilities may help encourage them to access such facility since it promotes the expectation that such schedule is exclusively for their peers with whom they can relate to.

4. **Make the visit to ISDN facilities a part of academic or educational activities or requirements.** A visit to any ISDN facility may be included as a requirement for a health or other related subject (e.g. values education or social studies). Coordinate such class or individual visit to any facility to ensure that all the students or adolescent groups intended to visit the facility will be efficiently received and accommodated in the facility.

5. **Partnership with local media.** Explore and build a partnership with media (e.g. radio) for the promotion of the ISDN and the available AHD services. Limited airtime, articles, or promotional spots may help in making the community aware of the AHD programs offered in the facility.

6. **Promote incentive and reward mechanism to encourage adolescents to visit the health and social facilities under the ISDN**. Some incentive schemes may be developed to motivate young people to visit health and social facilities. For example, an AHD Card may be provided after an adolescent's participation in an AHD class or activity. Such card may provide entitlement or incentive for accessing free health services or priority treatment for other services within the locality. Other incentive schemes may be designed and implemented in partnership with the private institutions within the locality. For example, products from private companies may be distributed for free for access to specific services.

7. **Continuously build champions and advocates.** Partner with popular personalities or decision makers as champions and advocates for AHD. Mobilize these personalities during AHD activities to encourage adolescents to access services.

In promoting the ISDN, it is important to involve the community and all stakeholders. Continuing promotion of the ISDN is likewise a strategy for sustaining the AHD program within a locality.

SECTION 8

MONITORING AND EVALUATING THE AHD AND ISDN PROGRAM

SECTION 8

MONITORING AND EVALUATING THE AHD AND ISDN PROGRAM

Monitoring and Evaluation (M&E) is important in determining whether the AHD program through its key strategies is working. All stakeholders want to be able to demonstrate results, understand how the ISDN or the AHD programs are working and assess how the programs interact with other events and forces in their communities.

The AHD program in general and the ISDN initiative in particularly can be strengthened through appropriate use of accurate monitoring and evaluation data. The ISDN members can assess the quality of activities and/or services and the extent to which the program is reaching its intended audience. With adequate data, they can set priorities for strategic planning, assess training and supervisory needs and obtain feedback information from the target audience or program participants. With knowledge on what worked and did not work, program managers can identify appropriate interventions to improve gaps, prioritize resource allocation, and reconfigure strategies to make it more effective.

M&E results can also help in ensuring the sustainability of the ISDN strategies and the entire AHD program. It can help stakeholders and the concerned community understand what the program is doing and its impact in the development of the adolescents and in overall community development. With appreciation of the impact of the program, key stakeholders work together to sustain the initiative and may pour more investments because they know that the program is contributing significantly in the total development of the community. Policymakers are likewise encouraged to develop policies that can institutionalize a successful AHD program. Moreover, with proper documentation, successful programs and initiatives may serve as models that can be replicated by other communities, thus, expanding the impact of the program. Through participatory M&E, communities are mobilized to support adolescent development and young people. The M&E results enable communities and youth to inform local leaders about youth needs and to advocate for funding. The results can identify better strategies, resources, and systems of support for adolescents. If the community is involved in the M&E, they can likewise develop a sense of ownership through participation, improve coordination and mobilize support for adolescents and the array of services that foster their health and development.

Monitoring is the routine tracking of a programs activities by measuring on a regular, ongoing basis whether planned activities are being carried out or expected outputs are achieved. Results reveal whether program activities are being implemented according to plan and assess the extent to which a programs services are being used.

Evaluation gathers information that measures how well program activities are performed based on its intended outcomes and impact. It aims to measure the quality of program implementation and to assess coverage and its impact on the change in behaviors of adolescents. Outcome evaluation determines whether outcomes that the program is trying to influence are changing in the target population. Impact evaluation, on the other hand, determines how much of the observed change in outcomes is due to the programs efforts.

1 DEVELOP M&E FRAMEWORK PLAN

WHO:

ISDN Members: The monitoring and evaluation of the effectiveness and efficiency of the AHD services and information being provided by the ISDN should be done through a participatory process. Involve all the members and other stakeholders including the target beneficiaries in monitoring and assessing the program. A participatory process ensures comprehensiveness and objectivity of the M&E data that can be gathered for making efficient and effective program and operational decisions.

WHAT:

The M&E framework serves as the basis for measuring expected results. It provides the targets and the performance indicators that measures program or project outputs, outcomes, and impact.

HOW:

1. **Review the AHD Results Matrix.** Refer back to the results matrix developed by the ISDN during the Action Planning (refer to sample in Annex I). Agree on key indicators for monitoring and evaluation.

2. **Develop an M&E Plan.** After reviewing the AHD program results matrix, define the scope of the M&E effort. Scope refers to the extent of the M&E activity that will be covered by the M&E activities. In determining the scope, take into consideration the following:

   a. Objectives or targets and the corresponding indicators to be monitored and evaluated. The objectives and targets identified in the planning stage of the ISDN shall serve as the basis in determining the scope of the M&E. It is important to always refer to the results matrix to monitor and evaluate the efficiency and effectiveness of the AHD program being implemented by the ISDN.

b. Source of data. It is likewise important to identify the available and potential sources of M&E data to ensure that needed information are gathered. It also helps determine needed resources for M&E activities.

c. Schedule of monitoring and evaluation. The schedule and timing of M&E is important for decision-making processes involved in program implementation. It also helps in scheduling needed resources based on the M&E activities to be conducted. Monitoring activities are done more regularly than evaluation.

d. Available resources including human and financial cost. The availability of personnel and budget needs to be considered in determining the scope of M&E. Interagency and participatory approaches particularly among ISDN in conducting M&E activities are more cost-efficient that designating the work of M&E to a single entity.

The goals, objectives and activities of the AHD program determines the scope of what will be monitored and evaluated. Monitoring usually involves the tracking of output indicators vis-à-vis the implementation plan (e.g objectives and targets). Evaluation focuses on the outcome and impact of the AHD interventions. A sample M&E Plan is provided in Table 6 below.

Table 6. Sample Monitoring and Evaluation Plan

Objectives	Indicators	M&E Activity / Methods	Timeline	Budget	Agency
To increase knowledge on ASRH of 10,000 adolescents in all barangays in 2018	10,000 adolescents with increased knowledge on ASRH information by type of adolescents (i.e. in-school and OSYs)	Checking of attendance sheet every IEC activity	Every after IEC activity	---	Agency conducting the activity
		Encoding of the names of adolescents who attended or participated in IEC activities in a database		30,000	ISDN Secretariat
		Administration of pre- and post-test among all participants in all IEC activities & analysis of results	Before and after IEC activ-ities	40,000	
	10,000 of adolescents who have used ASRH information in preventing early sexual engagement	Conduct of AHD program evaluation	March 2020	500,000	ISDN
To provide AHD-related activities to 5,000 adolescents in 2018	5,000 adolescents provided with ASRH services by type of adolescents (i.e. in-school and OSYs)	Checking of referral and back referral slips in the ISDN facilities/ teen center	Every quarter	3,000	ISDN Secretariat
		Submission and consolida-tion of reported number of adolescent client served by ISDN facilities	Every quarter	4,000	Members of ISDN and Secretariat
		Conduct random exit interviews	Annually	40,000	ISDN TWG

2 IMPLEMENT THE M&E PLAN AND UTILIZE THE RESULTS IN PROGRAM ENHANCEMENT

WHO:

ISDN Members: The implementation of the M&E plan should be a regular activity of the ISDN members. It is to be coordinated by the ISDN secretariat which also serves as the consolidating arm for M&E data and information.

WHAT:

This activity aims to ensure that M&E becomes an integral part of the operation of the ISDN.

HOW:

1. **Include M&E activities in the ISDN Action Plan and as an agenda in ISDN Regular Coordinative Meetings.** To ensure that M&E activities are implemented based on the plan, integrate the activities in the ISDN action plan which should be discussed as an agenda in every ISDN meetings. Emerging concerns in implementation should be discussed based on the inputs from M&E initiatives to ensure evidence-based decision-making in every ISDN coordinative meetings. Make updates and reporting of accomplishments vis-à-vis the objectives as part of the agenda of such meeting.

2. **Ensure implementation of M&E activities as scheduled.** To ensure the gathering of updated and relevant M&E data, implement the M&E plan as scheduled.

3. **Document, analyze, and utilize M&E results for the enhancement of the ISDN operation.** Store all M&E data in an accessible database. Process the results for analysis. In packaging the results, make use of more comprehensible and understandable presentation such as tables or graphs for easier utilization of the ISDN members.

   It is important that M&E data are utilized for identifying and implementing interventions to improve program implementation. M&E knowledge may be used in continuing or regular coordinative meetings or in periodic program implementation assessment and strategic planning. Results may also be disseminated to concerned stakeholders such as local chief executives and other officials or school administrators so they will be informed and will take appropriate action for program implementation improvement.

ANNEXES

ANNEX A

SAMPLE GUIDE FOR FOCUS GROUP DISCUSSION (FGD)

Consent Process. Consent forms for focus group participants are completed in advance by all those seeking to participate.

- Thank you for agreeing to participate. We are very interested to hear your valuable opinion on the various issues and concerns that adolescents of today face that are needing appropriate interventions.
- The purpose of this study is to gather and understand information from adolescents and other key stakeholders on the issues that they face today and which may have significant impact on their development. We hope to learn things that the Local Population Office or ___(state the office)___ can use to develop and implement appropriate interventions.
- The information you give us is completely confidential, and we will not associate your name with anything you say in the focus group.
- We would like to document the focus groups so that we can make sure to capture the thoughts, opinions, and ideas we hear from the group. No names will be attached to the focus groups and the documentation will be discarded as soon as they are trans-cribed.
- You may refuse to answer any question or withdraw from the study at anytime.
- We understand how important it is that this information is kept private and confidential. We will ask participants to respect each other's confidentiality.

If you have any questions now or after you have completed the questionnaire, you can always contact a study team member or contact our office.

Introduction:

1. Welcome the Participants.

   Introduce yourself and the note taker, and send the Sign-In Sheet with a few quick demographic questions (age, sex, years at this facility) to the group while you are intro-ducing the focus group.

   Review the following:
   - Who we are and what we are trying to do
   - What will be done with this information
   - Why we asked you to participate
   - If you are a supervisor, we would like to excuse you at this time

2. Explain the process.

   Ask the group if anyone has participated in a focus group before. Explain that focus groups are being used more and more often in health and human services research.

About focus groups

- We learn from you (positive and negative)
- Not trying to achieve consensus, we are gathering information
- No virtue in long lists: we are looking for priorities
- In this project, we are administering questionnaires and conducting focus group discussions. The reason for using both of these tools is that we can get more in-depth information from a smaller group of people in focus groups. This allows us to understand the context behind the answers given in the written survey and helps us explore topics in more detail than we can do in a written survey.

Logistics

- Focus group will last about one (1) hour
- Feel free to move around
- Where is the bathroom? Exit?
- Help yourself to refreshments

3. Agree on Ground Rules.

   Ask the group to suggest some ground rules. After they brainstorm some, make sure the following are on the list:

- Everyone should participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please do not have side conversations
- Turn off cell phones if possible
- Have fun

4. Turn on the Recorder.
5. Ask the group if there are any questions before starting and address those questions.
6. Introduce participants.

   Begin discussion:

   Discussion begins, make sure to give people time to think before answering the questions and do not move too quickly. Probe to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

Focus Questions:
For Teens/Adolescents (Boys and Girls)

a. What are the topics that interest you as a young person nowadays?
b. What do you think are the most pressing needs and issues of young people of today in your community? (*From the list of major issues, go through each major issue – e.g. teenage pregnancy*)
c. Why do you think young people are involved in these issues (i.e. causes of the issues identified)? (Probe on issues about their knowledge, attitude, and practice on the certain issue. Also probe possible institutional concerns such as lack of policies and programs, etc.)
d. Given these priority issues, how do you think the government or any institution/ community can solve or address these issues? *(Go through each of the major issues identified)*
e. What interventions or programs are present in your community? What is your involvement in these programs?
f. From whom do you want to get information about the issues you have identified? (E.g. school, parents, community leaders, media, etc).
g. Have you heard of a facility for teens? If yes, where did you learn about it? Have you been to any of these facilities? Describe this facility. (*If they answered negatively, describe how a teen center looks like*)
h. Do you think a Teen Center or facility for adolescents in the community would be an effective intervention to address the issues you have identified?

- Would you visit the said Teen Center? Why?
- What activities would you like to have in a facility for teens or the activities which will interest or encourage you to visit the facility?
- What services would you like to have in a facility for teens? Who would you like to deliver these services (e.g. health service providers or young people)?
- What areas (area for games, counseling room) would you like to see in a facility for teens?
- What activities would you like to be involved in?
- Where should the Teen Center be located for you to access it regularly?
- What specific time would you want to go to if there is such a facility?
- What would you call such facility?
- What are the messages you would like to hear for your concerns?

i. What other programs should the government provide to address your concerns or young people' concerns in your community?

For Parents

A. What do you think are the most pressing needs and issues of young people of today in your community?

B. (*From the list of major issues, go through each major issue – e.g. teenage pregnancy*)

i. Why do you think young people are involved in these issues (i.e. causes of the issues identified)? (Probe on issues about their knowledge, attitude, and practice on the certain issue. Also probe possible institutional concerns such as lack of policies and programs, etc.)

ii. What are the roles of parents in these issues?

C. As a parent, how do you discuss issues related to sexuality (e.g. menstruation, masturbation, sexual relationships, etc.) with your adolescent children? What are the barriers in communicating with your adolescent children about sexuality? Do you think you should be discussing or advising your adolescent children about sexuality? Who should provide them information?

D. Given the priority issues, how do you think the government or any institution/ community can solve or address these issues? *(Go through each of the major issues identified)*

E. What interventions or programs are present in your community?

F. Do you think a Teen Center (describe a Teen Center) in your community would be a viable or effective intervention to address the issues of adolescents in your community? What are its potential benefits? What are its potential problems?

G. What services and information should be provided in the Teen Center?

H. How would you encourage your adolescent children to access the facility?

I. If they are sexually active, would you recommend them to access contraceptive methods?

J. What other roles you can perform to promote the Teen Center?

For Service Providers/Barangay Officials (FGD or KII)

a. What do you think are the most pressing needs and issues of young people of today in your community?

b. (*From the list of major issues, go through each major issue – e.g. teenage pregnancy*)

c. Why do you think young people are involved in these issues (i.e. causes of the issues identified)? (Probe on issues about their knowledge, attitude, and practice on the certain issue. Also probe possible institutional concerns such as lack of policies and programs, etc.)

d. What are the roles of service providers and barangay officials in these issues?

e. Given the priority issues, how do you think the government or any institution/ community can solve or address these issues? *(Go through each of the major issues identified)*

f. What interventions or programs can you recommended that are already present in your community?

g. Do you think a Teen Center (*describe a Teen Center*) in your community would be a viable or effective intervention to address the issues of adolescents in your community? What are its potential benefits? What are its potential problems?

h. What services and information should be provided in the Teen Center?

i. How would you encourage adolescents to access the facility?

j. What other roles you can perform to promote the Teen Center?

8. Conclude the discussion:

> *That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us. We have a short evaluation form that we would like you to fill out if you have time. If you have additional information that you did not get to say in the focus group, please feel free to write it on this evaluation form.*

Materials and supplies for focus groups

- Sign-in sheet
- Consent forms (one copy for participants, one copy for the team)
- Evaluation sheets, one for each participant
- Name plates
- Pads & Pencils for each participant
- Focus Group Discussion Guide for Facilitator
- 1 recording device
- Permanent marker for marking documentation with FGD name, facility, and date
- Notebook for note-taking
- Refreshments

ANNEX B

SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS TODAY

Adolescence is a time of sexual exploration and expression. As their bodies change and mature, many adolescents develop an interest in sex and begin to have sexual relations. The consequences of unprotected sex in adolescents include too early and unwanted pregnancy, and sexually transmitted infections, including HIV[1].

Early and Unwanted Pregnancy

When an adolescent girl becomes pregnant, she is at risk of complications during pregnancy and delivery. Her baby is also at risk of health problems, even death. As a consequence of early childbearing, adolescent mothers are often unable to continue schooling and fulfill their aspirations and dreams in life. Corollary to that, adolescent fathers also face some of the issues that adolescent mothers do. They face the challenges of lack of emotional maturity to handle relationships. The lack of knowledge and skills, poor access to contraceptive methods and vulnerability to coerced sex put adolescents at high risk of unwanted pregnancies and sexually transmitted infections.

Sexually Transmitted Infections

At the time of first sexual contact, adolescents often lack knowledge about sexuality and reproduction. Generally, their first sexual engagement is unprotected which places them at risk of getting sexually transmitted infections (STIs) and unwanted pregnancy. When left undiagnosed and untreated, STIs will continue to afflict them in their adult life and may lead to certain health conditions such as pelvic inflammatory disease, ectopic pregnancy, and eventually, infertility. The children they bear may also be at risk of damaged eyesight and poor general health condition. A female also runs the risk of getting the virus that causes cervical cancer if her first sexual activity was in early adolescence[2].

HIV and AIDS

Young people are vulnerable to HIV infection because of risky sexual behavior, substance abuse, and lack of access to information and prevention services. Many young people do not know that HIV is a threat to them but many do not know how to protect themselves from acquiring HIV infection. Among the most affected young populations in the country today are young males who have sex with males, young males who have sex with both males and females, young sex workers, and young persons who inject drugs. Their sexual initiation starts during adolescence. Furthermore, they have low knowledge about HIV and low perception of risks of having HIV infection[3]. Finally, they have poor access to HIV information and services.

[1] World Health Organization (WHO). Orientation Programme on Adolescent Health for Health-care Providers: Handout, New Modules. 2006:C-7.
[2] World Health Organization (WHO). Orientation Programme on Adolescent Health for Health-care Providers: Handout, New Modules. 2006:C-10.
[3] Department of Health (DOH). The Growing HIV Epidemic Among Adolescents in the Philippines at http://www.doh.gov.ph/node/5783.

Sexual Violence

Adolescent girls may usually lack the power, confidence and skills to refuse to have sex. Girls are most often raised to become submissive females, while boys are raised to become dominant males. These gender roles and norms make it difficult for a girl to say no to sex. Consequently, sexual violence such as sexual abuse, coercion, and rape, happens. Sexual violence can result in unwanted pregnancy and STIs including HIV, in addition to long lasting psychological consequences.

Teen Pregnancy: A National Catastrophe

More than its demographic implications, early pregnancy among adolescents poses life-long implications that may likely undermine their capacity to achieve their aspirations. Without such capacity, adolescents may not be able to productively contribute as members of the human resource of the country (Commission on Population, 2017).

Table 1. Number of births by teenage pregnancy (10-19 years old), Regional Data: 2011-2015 (Philippine Statistics Authority, 2016)

Region	2011	2012	2013	2014	2015
ARMM	383	1,056	1,076	1,208	1,288
CAR	3,934	3,961	4,053	3,869	3,576
NCR	27,098	27,015	27,248	26,606	25,199
REGION I	11,014	10,564	10,694	10,398	10,108
REGION II	8,925	9,285	9,279	9,285	8,794
REGION III	23,900	24,895	24,532	24,729	24,573
REGION IV-A	28,694	29,135	29,217	28,605	28,612
REGION IV-B	5,593	5,963	6,015	6,212	6,403
REGION IX	7,526	7,400	7,130	7,861	7,611
REGION V	12,228	12,610	12,695	12,719	12,498
REGION VI	12,353	12,985	12,957	12,736	12,891
REGION VII	16,628	17,359	16,927	16,708	15,848
REGION VIII	8,425	8,707	8,668	9,155	9,549
REGION X	10,950	11,522	11,644	11,971	11,928
REGION XI	12,271	12,045	11,730	12,195	13,068
REGION XII	8,987	10,169	11,161	10,721	10,965
REGION XIII	4,744	4,603	4,554	4,894	4,912

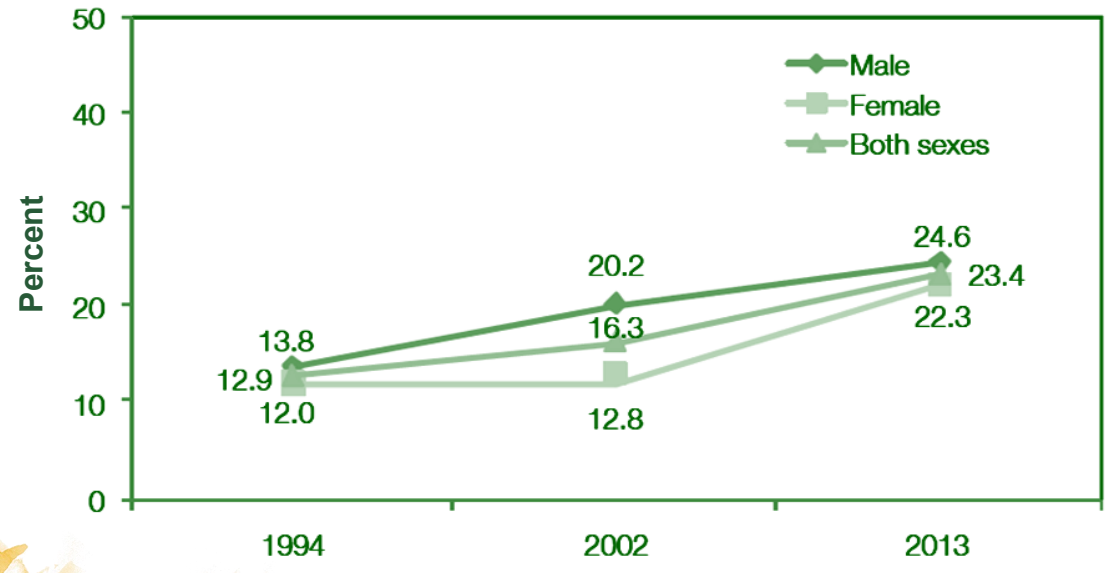
Social science experts admit that teenage pregnancy nowadays has evolved into a symptom of dire economic conditions rather than a cause of it (Hor, 2014). Teenage pregnancy fuels the cycle of poverty and discrimination because most pregnant adolescents and youth are jobless, and thus, face greater financial miseries in life. School leaving and inability to take on further education or skills training are the reasons for these woes.

In a recent online article publication, teenage pregnancy has been labeled an epidemic that forces girls to drop out of school (Santos, Urgent response needed to address teen pregnancy, 2012). Another publication reported that teen pregnancy in the Philippines has reached national calamity status (Santos, HIV and teen pregnancy: A national youth crisis, 2014). Furthermore, among the six major economies in the Association of Southeast Asian Nations (ASEAN), the Philippines posed the highest rate of teenage pregnancies and is the only country where this rate has been steadily increasing (Hor, 2014). Sociologists warn that if this increasing trend continues, teenage pregnancy will become a huge problem for the Philippines (Humanitarian News and Analysis, 2013).

The 2013 National Demographic and Health Survey (NDHS), the tenth in a series of surveys conducted by the Philippine Statistics Authority (PSA) every five years since 1968, confirmed the dreaded forecast in teen pregnancy in the Philippines on the strength of their findings. Following are the highlights of the NDHS 2013 findings on teen pregnancy (Philippine Statistics Authority, 2014):

1. One in ten young Filipino women age 15-19 have begun childbearing, of which 8% are already mothers and another 2% are pregnant with their first child. Among the age 20 to 24 groups of women, 43% are already mothers and 4% are pregnant with their first child.
2. One in five young adult Filipino women age 18 to 24 years had initiated their sexual activity before age 18. Some of them would have had their first intimate sexual act before marriage. The survey reveals that 15% of young adult women age 20 to 24 had their first marriage or began living with their first spouse or partner by age 18. Initiation of sexual activity before age 18 is more common among young adult women with less education and those in poorer households.

Figure 1. Trend in sexual initiation before age 18 among youth aged 18-24, by sex: 1994, 2002 and 2013 (Demographic Research and Development Foundation and University of the Philippine Population Institute, 2014)



Sexual initiation signals the start of exposure to the risk of pregnancy and childbearing before age 18. Figure 1 shows that sexual initiation increased from 13 percent in 1994 to 23 percent in 2013 for both sexes.

3. Early pregnancy and motherhood varies by education, wealth and region. It is more common among young adult women age 15 to 24 with less education than among those with higher education. The proportion of young adult women who have begun childbearing is higher among those classified as belonging to poor households than those in wealthier households.

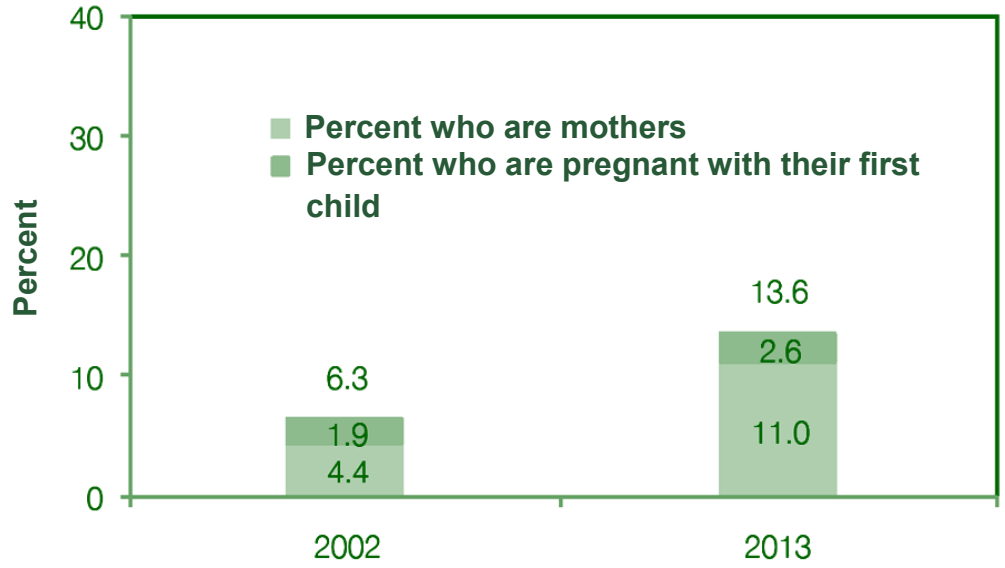
4. Over 40% of young adult women with some elementary education, compared with only 7% of those with college education, reported having their first intimate sexual act at age 18. Similarly, 36% of young adult women in the lowest wealth quintile, compared with only 10% of those in the highest wealth quintile, had their first intimate sexual act before age 18. The proportion of young adult women reporting first intimate sexual act before age 18 is 22% for rural areas and 17% for urban areas. Among young women age 15 to 24, 2% reported initiating their sexual activity before turning 15.

The 2013 Young Adult Fertility and Sexuality study (YAFS) 4, the fourth in a series of cross-sectional surveys on Filipino youth aged 15 to 24 also provided a wealth of data and information on the state of teen pregnancy in the Philippines. The succeeding information highlights the YAFS4 findings on teen pregnancy in the country (Demographic Research and Development Foundation and University of the Philippines Population Institute, 2014):

1. The proportion of 15-19 year olds who had begun childbearing increases with age, beginning at 15. Among the 15-year olds, 2% have started childbearing. This proportion increases steadily such that among 19-year olds, 35.2% have already begun childbearing. Figure 2 compares the trend in teenage fertility in 2002 and 2013.

2. Over the twenty year period covered by YAFS, teen fertility proportion rose dramatically in the last 10 years, doubling from 6.3% in 2002 to 13.6% in 2013. In 2013, 11.0 percent of the 15-19 year olds were already mothers while another 2.6 percent were pregnant with their first child when they were interviewed. Figure 2 contrasts teenage fertility between 2002 and 2013.

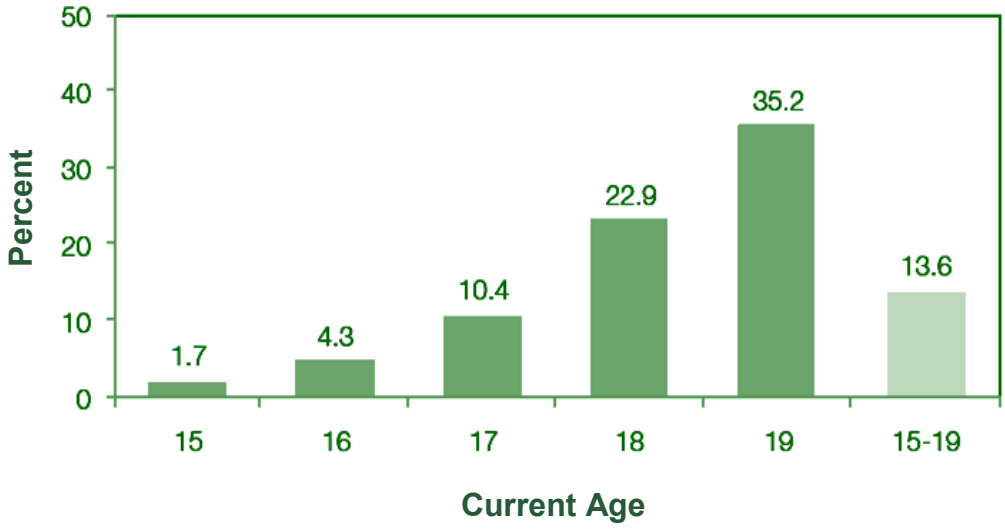
Figure 2. Teenage fertility: 2002 and 2013 (Demographic Research and Development Foundation and University of the Philippines Population Institute, 2014)



3. Teenage childbearing is highest among those with elementary education (26%) and high school graduates (23%). It is lowest among the college educated (7%).

4. The proportion of the 15-19 year olds who had begun childbearing increases with each age, beginning at 15. Among the 15-year olds, 2 per cent have started childbearing. This proportion increases steadily such that among 19 year olds, 35.2 per cent have already begun childbearing.

Figure 3. Teenage fertility by current age (Demographic Research and Development Foundation and University of the Philippines Population Institute, 2014)



The counterpart measure of teenage childbearing among men is the proportion of 15-19 year old males who reported that they had gotten someone pregnant. Unlike teenage childbearing this measure may be prone to bias as males may not always know whether or not they had fathered a child. Still, the YAFS results show that among 15-19 year old males, 2.4% reported having gotten someone pregnant. There is no distinct education difference.

The YAFS is conducted by the University of the Philippines Population Institute (UPPI) and the Demographic Research and Development Foundation (DRDF) once in 10 years. Started in 1982, it is the only survey of adolescents that is nationally and regionally representative providing updated information on a broad framework of adolescent sexuality and reproductive health (ASRH) issues that can be used in various intervention measures that safeguard the health and well-being of adolescents and youth.

YAFS 4 researchers disclosed that the frequency of teenage girls who have become pregnant across the country has more than doubled in ten years (Demographic Research and Development Foundation and University of the Philippines Population Institute, 2014). They also lamented that 78% of the youth surveyed are not using any form of contraception or protection when having sex for the first time. Further, YAFS 4 researchers suspect that the narrowing of the gap in the prevalence of early sexual activity between young men and women that they have stumbled upon in the course of their research is likely a major contributor to the sharp increase in teenage fertility in the Philippines.

For nearly 20 years of YAFS study, the proportion of females aged 15-19 who had begun childbearing or women who were either pregnant or had already given birth at the time of the survey, has risen only during the last 10 years. Alarmingly, the NDHS 2013 findings corroborated the YAFSS 4 results on the aspect of increasing teen fertility trend.

Reasons for Becoming Pregnant Among Teens

In the Philippines, the reasons for becoming pregnant among teens range from unplanned sexual encounters and peer pressure to lack of information about protected sex, breakdown of family ties, lack of good female role model in the home and the absence of accessible and adolescent-friendly clinics (Hor, 2014). Filipino teens from poor socioeconomic settings are disproportionately represented among pregnant teenagers. Children who long for love and care from their parents tend to seek love and care outside the home – usually with friends and peers. This lack of parent guardianship as teens mature towards independence is one of the causes of teen pregnancy (Cummins, 2015). Many adolescents, male and female, also report being coerced by peers to have sex against their will.

Teenagers who bear their own children through ignorance, carelessness and passivity in a society that offers limited opportunities, deprive not only themselves of a bright future but their children as well. Along the same vein, many young girls say they want to try family planning methods, however, this decision is made only after having given birth to their first child. Apparently for adolescents, the use of contraceptives is only an afterthought (Humanitarian News and Analysis, 2013).

Effects of Teenage Pregnancy

Medically, motherhood at a very young age entails risks. Maternal death is one of these. The other critical health risk factors for teen pregnancy include inadequate nutrition due to poor eating habits, reproductive organs that have not reached physiological maturity and are therefore unprepared for childbearing or childbirth and eclampsia, a convulsive condition among pregnant women characterized by high blood pressure, generalized edema or large volume of fluid in the circulatory system and tissues and excess serum protein in the urine (The Fee Dictionary, 2015). Data from the World Health Organization (WHO) also show a high and increasing incidence of fetal death among Filipino mothers below 20 years of age (Hor, 2014). This report tends to gravitate towards the fact that children of young mothers face both morbidity and mortality risks.

Early childbearing has also been an impediment to the improvement of the educational, economic and social status of young women as it curtails their livelihood and employment chances. This could have long-term adverse impact on the quality of life of both mother and child. Early pregnancy and childbirth also have demographic implications. Pregnancy at a young age implies longer sexual exposure to the risk of pregnancy than those who enter into marital unions at a later age (Natividad, 2013). Demographically, this means higher fertility that translates to increased number of young dependents both at the household and national levels.

The cost of teen pregnancy from the day a teen female tested positive for pregnancy until her firstborn reached exactly one year of age is estimated by the National Youth Commission to reach P270,000.00 (Saavedra, 2015). A deeper study on the cost of teen pregnancy in the country has placed estimates at about P33 billion in lost potential lifetime income of women who get pregnant or give birth in their teen years (Ciriaco, 2016). Ciriaco added that according to UP Economist Dr. Alejandro Herrin, a teenager who gets pregnant and does not finish high school may potentially lose earnings of up to P83,000.00 a year when she gets paid for work at age 20. Herrin also predicted that early childbearing will reduce the probability of high school completion among teen females, hence, he suggested that policies on reducing early childbearing are likely to have substantial impact on the education and economic conditions of women and their families.

Another recent study by demographer, Corazon Raymundo, cited risk behaviors and effects of teenage pregnancy on the social environment of a Filipino girl. Raymundo reported that smoking, alcohol and drug use among teens may predict the likelihood of teen pregnancy. Raymundo also warned that living away from home, being idle or doing nothing and having older siblings who have gotten pregnant or given birth in their teen years are predictors of early sexual engagement and teenage pregnancy (Ciriaco, 2016).

Currently, there are no specific and direct laws that address the growing problem of teen pregnancy in the country. The RPRH Law, more popularly known as Republic Act No. 10354, contains provisions which include sex education and the use of contraceptives by adolescents with parental consent, only highlights the bleak reality that addressing teenage pregnancy is difficult to manage because adolescents cannot be controlled in their emotions and risk-taking attitude (Youth Problems in the Philippine Society, 2013). On the brighter side, sociologists outside the country are in agreement that teen pregnancy declines with improved economic opportunities, reduced poverty, and improved prospects for other adult outcomes. They added that early childhood education programs and improved access to financial aid to attend college are the other types of interventions that have been proven effective in enhancing the aforesaid opportunities in a cost-effective manner. Other experts propose addressing teen pregnancy by way of addressing inequality and lack of social mobility (Kearney & Levine, 2012) referred to as the movement of individuals, families, households, or other categories of people within or between layers in society and determined in terms of change in income or wealth.

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ANNEX C

SAMPLE TOOL FOR THE INVENTORY AND MAPPING OF AVAILABLE AHD INFORMATION AND SERVICES

BASIC INSTITUTIONAL INFORMATION		
Name of Organization or Facility:		TAÑONG HEALTH CENTER
Head of the Organization of Facility		DR. MARIA SHAREN P. GUEVARRA-REY
Con-tact Details:	**Address:**	7 Lopez Jaena St.,Tanong, Marikina City 477-8843 (Tanong Brgy.Hall)
	E-mail Add:	tanong@gmail.com
	Contact No.	(02) 531-6650

SERVICES AND PROGRAMS/ PROJECTS FOR ADOLESCENTS (AGED 10-19) PROVIDED BY THE ORGANIZATION OR FACILITY

AHD Service/ Programs	*Schedule of Service	Geographic Area Coverage	Target clients or beneficiaries	Cost	Remarks
Primary Health Care (e.g. dental, medical check-up, etc.)	Everyday 9:00am-4:00pm	Bgy. Tanong, Marikina City	Population aged 10-19	Free	
Family Planning	Tuesday 1:00-5:00pm	Bgy. Tanong, Marikina City	WRA (15-49)	Free	

*Only for AHD services (not for programs)

ANNEX D

SAMPLE DATABASE OF AVAILABLE INFORMATION AND SERVICES

Name of Institution or Facility	Head of the Organization/ Facility	Contact Information			AHD Services or Programs Provided				
		Address	Email	Contact No.	Type of AHD Service/ Program	Schedule of Service	Geographic Coverage	Target Clients	Cost
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

ANNEX E

ISDN DIRECTORY FORMAT

Institution/ Facility	Address	Contact No.	Email Add	AHD Services Offered	Schedule of Services
Example:					
Bgy. Uno Health Station	Poblacion East, Nagcamaran, Ilocos Norte	(078) 531-6788/ 0917-8889189	bgyuno@gmail.com	Pre- and post-natal check-up	Every Monday
				Dental services	Every Tuesday

ANNEX F

SAMPLE REFERRAL FORM

FORWARD REFERRAL SLIP							
Initiating Facility Name and Address:				Date of referral:			
Referred by:	Name:		Position:	Signature:			
Telephone arrangements made:	YES	NO	Facility Tel No.	Fax No.			
Referred to Facility Name and Address:							
Client Name							
Identity Number				Age:	Sex:	M	F
Client Address							
Initial Assessment Findings:							
Treatment Given:							
Reason for Referral:							
Referral Received by:	Name:		Signature:	Date:			
Note to receiving facility: On completion of client management please fill in and detach the referral back slip below and							

----------"----------*receiving facility - tear off when making* ***back referral***----------"--------

BACK REFERRAL SLIP					
Back Referral from		Tel No.	Fax No.		
Reply from (person completing form)	Name:		Date:		
	Position:	Specialty:			
To Initiating Facility: *(enter name & address)*					
Client Name					
Identity Number		Age:	Sex:	M	F
Client address					
This client was seen by: *(give name & specialty)*			on date:		
Client Initial Findings:					
Special Investigations and Findings					
Diagnosis:					
Services Provided:					
Recommendation:					
Refer Back to:			on date:		
Referral Received by:	Name:	Signature:	Date:		

ANNEX G

SAMPLE REFERRAL REGISTERS

Register of Referral (OUT)

No	Date Referral Made	Client's Name	Sex		Identity No.	Referred to (name of facility)	Referred for (reason for referral)	Back Referral received on (date)	Follow-up Required (Y/N)	Follow-up Completed (Y/N)
			M	F						
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Register of Referral (IN)

No	Date Referral Received	Client's Name	Sex		Identity No.	Referred from (name of facility)	Referred for (reason for referral)	Initial Services Provided	Back Referrals Sent on (date)
			M	F					
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

ANNEX H
SAMPLE PARTNERSHIP AGREEMENT

STRENGTHENING AND MOBILIZING THE INFORMATION AND SERVICE DELIVERY NETWORK (ISDN) FOR MARIKINA CITY ADOLESCENT AND YOUTH HEALTH AND WELLNESS PROGRAM

WHEREAS, the City Government of Marikina recognizes the vital role of adolescents and youth in the human and socio-economic development of the city and the City Government's primary responsibility to create an enabling policy and program environment for adolescent health and youth development;

WHEREAS, the full and integrative development of young people in Marikina City is critically challenged by existing and emerging concerns particularly those affecting their health including sexuality and reproductive health concerns including the issues on increasing teenage pregnancy, incidence of sexually transmitted infections and HIV/AIDS, illegal drugs and substance use and abuse, smoking, and other related issues;

WHEREAS, the City recognizes that addressing these critical concerns affecting young people entails the close collaboration and collective actions from all stakeholders including the concerned local government departments, civil society organizations particularly those catering services for young people's concerns and the religious sector, and the private sector, for more strategic and effective interventions;

WHEREAS, the City Government of Marikina adopts and promotes the establishment of Information and Service Delivery Network (ISDN) for the Marikina City Adolescent and Youth Health and Wellness (MYHAW) program to link information and service delivery interventions for adolescent and youth health-related needs and to foster partnerships, well-coordinated, multisectoral and interagency, and comprehensive provision of health and development interventions for young people in Marikina City;

NOW THEREFORE, for and in consideration of the foregoing, we the members and key institutional players of the ISDN for MYHAW Program agree as follows:

Section 1. Objectives of the ISDN for MYHAWP. The ISDN for Marikina City Adolescent and Youth Health and Wellness Program generally aims to promote the holistic and integrative wellness and wellbeing, empowerment, and responsible behaviors including responsible sexuality among adolescents (10-19 years) and youth (20-24 years) in Marikina City. It specifically aims to:

- Ensure sustainable availability and accessibility of adolescent and youth-friendly, age-appropriate, and need-based information and services for the health including sexuality and reproductive health-related needs of adolescent and youth in the city;

- Link communication and demand generation interventions (demand side) and service delivery mechanisms addressing health related concerns of young people to ensure continuum of care;
- Engage all stakeholders including the claim holders (adolescents and youth) and duty-bearers (institutions and organizations) to promote participatory and youth-centered approach to fostering adolescent and youth health and wellness in the city;
- Promote an enabling environment and positive behavior among young people to access appropriate information and services they need to achieve their development goals and aspirations.

Section 2. Composition of the ISDN. The ISDN shall be a network of facilities and organizations providing information and services for the health and wellness-needs of adolescents and youth in the city. The ISDN shall generally include as its members the following institutions and organizations:

- Marikina City Health Office (through the Marikina Adolescent and Youth Health and Wellness Center (MYHAWC);
- All Barangay Health Centers;
- All Barangay Government Units;
- Public Hospital (Amang Rodriguez Medical Center);
- Private Clinics and Hospitals;
- CSOs including youth-serving organizations;
- Sangguniang Kabataan Federation;
- Public institutions and facilities catering for adolescent and youth health and social concerns;
- All public and private secondary and college schools;
- Relevant regional government agencies (DOH, POPCOM, DSWD, DepEd, TESDA); and
- International development partners.

The specific ISDN member agencies and partners are enumerated in "Annex A" which shall form an integral part of this Agreement. The membership of the ISDN may be expanded as needed upon determination and approval of the ISDN Steering Committee.

Section 3. Roles and Functions of the ISDN. The ISDN Management Committee shall perform the following specific roles and functions:

- Develop, implement, monitor, and evaluate an efficient coordinative, collaborative, and referral mechanism to ensure the continuum, availability, and accessibility of information and services for young people in the city through the following strategies:
    i. Identifying the needs of the priority segment of young people;

ii. Mapping available health care providers (personnel and facilities) that can serve the needs of priority population on appropriate health information and services;

iii. Designating priority segment of adolescents and youth to appropriate facilities; and

iv. Monitoring the utilization and provision of adolescent and youth health services.

- Mobilize members and partners to deliver of information and core package health care services for young people in an integrated and coordinated manner;
- Enforce regulatory measures and guidelines related to the establishment and operation of health facilities within the ISDN and related to the provision of information and services ensuring its adherence to the requirement of confidentiality, parental consent among minors, informed consent and voluntarism (ICV) in family planning, HIV-testing and other related health services as mandated by RA 10354 (Responsible Parenthood and Reproductive Health Act);
- Ensure an enabling and adolescent-friendly facilities;
- Ensure adequate and capable service providers and human resources at all times and at all levels of health care (i.e. health facilities, schools, and communities);
- Develop resource-sharing mechanisms and foster public and private sectors partnership in the delivery of information and services for adolescents, in a way that is beneficial to both parties;
- Develop a consolidated work and financial plan to ensure its sustainable operations;
- Generate needed resources for its planned strategies and activities including entering into partnerships with international and national development partners;
- Consult, conceptualize, develop, and advocate for enabling policies, including budget support for the sustainability of the ISDN operations;
- Develop and implement a monitoring and evaluation scheme; and
- Identify, discuss, and resolve emerging technical and operational issues among its members.

ISDN Management Committee. To provide overall technical direction and guidance in the organization and operations of the ISDN for MYHAWP, an ISDN Management Committee shall be organized and mobilized. Specifically, the Committee shall establishes appropriate management arrangements including the schedule of TWG meetings, collecting and consolidating reports on a regular basis, establishment of needed data and information base, communication protocols and financial management.

The Committee shall be composed of the principals and senior officials or representatives of the agency members of the ISDN identified in Annex A. The Chairperson of the Committee shall be elected from among its members and shall serve

The Marikina Adolescent and Youth Health and Wellness Center (MYHAWC) with the leadership and supervision of the designated AYHD Focal Person shall provide Secretariat support to the ISDN.

Section 4. Commitments, Roles, and Responsibilities of ISDN Members and Partners. Each of the ISDN members/partners hereby commits to perform the following roles and responsibilities:

1. Marikina City Government / City Health Office

The City Government through the City Health Office shall perform the following roles and functions:

- Take the lead in organizing and mobilizing the ISDN for MYHAWP in the achievement of its objectives and performance of its roles and functions;
- Take the lead in the development and implementation of the city sustainable adolescent health strategy and plan;
- Ensure that all adolescents in schools, training centers, and in communities have an updated and a designated network of functional health facilities providing the full range of reproductive health care on through the established referral system for the ISDN;
- Ensure and/or generate adequate allocation for the activities of the ISDN and conduct of other related strategies and interventions for young people;
- Support the capacity-building of the ISDN members and partners including their educators, service providers and facilities;
- Take the lead in conducting information campaigns to increase demand and utilization of adolescent health services in Marikina; and
- Ensure an enabling policy environment for young people through the enactment of supportive policies for adolescent health and development.

2. Marikina Adolescent and Youth Wellness Center

- Serves as the secretariat, convenor and coordinator of the ISDN in Marikina City;
- Provides adolescent information and health services such as dental, counseling, diagnostic (HIV screening and testing), and other health services as one of the end-referral facility within the City of Marikina;
- Refers to higher level facility the treatment of complicated diseases or psycho-social issues (e.g. gender-based violence) among adolescents and youth clients;
- Leads in the development of the adolescent health strategy in the city;
- Mobilizes members of the ISDN and regional partners in the conduct of collaborated adolescent health interventions;

- Develops, produces, and disseminates relevant IEC materials;
- Recommends to CHO training support for AHD focal persons and service providers in barangay health centers and in other ISDN members;
- Develops and disseminates ISDN directory to all agencies and schools and other stakeholders in the city; and
- Recommends to the ISDN and to the City Government policy and program interventions to strengthen the ISDN and the adolescent health strategy in the city.

3. Barangay Government Units

- Mobilize available barangay resources including budget, facilities, equipment, and human resources for adolescent health and wellness interventions in their respective barangay in collaboration with other ISDN members and partners;
- Mobilize the Barangay SK to develop strategies and interventions for adolescent and youth health including initiatives to prevent teenage pregnancy and to allocate corresponding fund from the SK fund (10%) as part of their youth development programs and projects and the Barangay Development Plan and Annual Investment Program;
- Support the barangay health center staff, community health volunteers, and peer educators and partner agencies in identifying and mobilizing adolescents in the locality to participate in activities promoting adolescent health and development;
- Promote parental responsibility and capacity for responsible parenting of their adolescent children in collaboration with appropriate ISDN members and partners;
- Promote and support the ISDN established referral systems and coordinative mechanisms by ensuring that adolescents needing services are promptly referred to the barangay health centers or to appropriate health care facilities and social institutions;
- Enact and implement supportive policies for adolescent health and youth development in the barangay;
- Support and conduct information campaign to increase the demand and utilization of adolescent health services in Marikina particularly in the prevention of risky behaviors such as teenage pregnancy, drugs and substance abuse, smoking and other related behaviors among young people; and
- Participate in assessing the progress of the adolescent health interventions in their *barangay* and in the city.

4. Barangay Health Centers and Community Health Volunteers

- Ensure that the health facility and its service providers and services are adolescent-friendly by building the capacity of its personnel on adolescent health based on the standards set in adolescent job aid, ensuring confidentiality, and availability of quality and appropriate health care information and services observing legal requirements for minors;

- Allocate or set an exclusive time or schedule for adolescent services;
- Refer promptly to higher level facility the treatment of complicated diseases or psycho-social issues (e.g. gender-based violence) among adolescents and youth clients;
- Coordinate with schools, barangays, and other stakeholders on the availability and access of services in the health facility;
- Support education and communication strategies in schools, communities, and in the workplace on the promotion of more positive and healthy behaviors among adolescent particularly on responsible sexuality;
- Maintain database and submit processed reporting data and information to MYHAWC and CHO on adolescent health;
- Conduct house-to-house and community visits for mapping of health needs among adolescents, provide appropriate information and education, and corresponding referral;
- Educate parents on appropriately guiding adolescents on responsible sexuality; and
- Support the barangay government in the identification and implementation of adolescent health related policy and program interventions.

5. Public and Private Hospitals and Clinics

- Serves as the end-referral for adolescent and youth health care needs;
- In addition to services available in the primary health care facilities, provides quality and adolescent-friendly tertiary level of health care for health needs of adolescents and youth in the city;
- Ensures that its personnel are properly trained and capacitated to be adolescent-friendly health service providers based on the standards set in adolescent job aid;
- Support the provision of affordable health services among indigent adolescents; and
- Support medical outreach and promotional activities among young people in schools, communities, and workplaces.

6. Public and Private Schools and Department of Education (DepEd)

- Through its schools and other learning centers, the DepEd integrates in relevant subject areas age and development- appropriate reproductive health education in consultations with parents-teachers-community associations, school officials, and other interest groups;
- Endeavors to capacitate the teachers on adolescent sexuality and reproductive health education in collaboration with the ISDN regional partners (e.g. DOH and POPCOM);
- Promotes and implements the ISDN referral system for the needed health services of school children through the adolescent-friendly school clinics by providing students with the directory of health facilities and the corresponding available services as part of IEC materials;

- Provides initial diagnostic and counseling for adolescents in school needing health or psycho-social treatment using the adolescent job aid;
- Endeavors to require high school students in collaboration with the barangay health center or MYHAWC to visit public or private health facilities within their communities for check-up and treatment of diagnosed illnesses at least once during the academic year as part of their academic requirement under MAPEH subject;
- Conducts or organizes in collaboration with ISDN partner agencies communication strategies such as symposiums, peer-to-peer education and interactive approaches (e.g. TeenChat on Adolescent Health and Responsible Sexuality of POPCOM) and other related interventions; and
- Capacitates and educates parents in collaboration with the PTA and concerned partner agencies (e.g. POPCOM and DSWD) on appropriately guiding young people into responsible sexuality.

7. Civil Society Organizations and Youth Organizations

- Support the demand generation strategies and provision of quality services to adolescents in the city in collaboration with the ISDN members and partners; and
- Conduct social mobilization and advocacy initiatives to improve the policy and program environment for integrated adolescent health and development at the barangay and city levels.

8. Sangguniang Kabataan

- Integrate adolescent health related interventions in the SK development plan using part of the 10% SK fund;
- Engage adolescents and youth in the development and implementation of health-related interventions through participatory and consultative approaches;
- Develop and conduct promotional activities and campaigns (e.g. symposia, workshops) as a sustainable SK interventions for the promotion of positive behaviors among young people particularly on responsible sexuality and non-engagement in risky behaviors such as smoking and drug use;
- Promote positive behaviors (e.g. responsible sexuality) among SK members through the social media;
- Promote the existing ISDN and referral system to improve positive health-seeking behaviors among young people;
- Develop and recommend policy interventions for adolescent health and responsible sexuality to the Sanggunian at the barangay and city level; and
- Promote role-modeling in the advocacy for responsible sexuality.

9. Other Public and Private Institutions for Adolescent Concerns

- Support the provision of integrated services for the special needs (e.g. psychological, mental, rehabilitation, etc.) of young people in the city;
- Collaborate with other ISDN members in the provision of
- Make and accept referral among members of the ISDN for specialized care and interventions; and
- Mobilize resources in support of adolescent health and wellness related interventions in the city.

10. Regional Partner Agencies

(A) Commission on Population and Development-NCR

- Provides technical assistance and support to the establishment and operation of the ISDN particularly in the areas of capacity-building especially for non-health stakeholders, research, plan and policy development, database management, and advocacy; and
- Assists in the design and conduct of IEC materials and other communication interventions.

(B) Department of Health-NCR

- Provides technical assistance and support to the ISDN and their individual components, organizations, and entities in the identification of appropriate interventions and in planning for the implementation of the Adolescent Health strategy;
- Assesses the capacities of health facilities and providers and officially designate adolescent coordinators in the facilities of the SDN;
- Facilitates the link of DOH-retained hospitals, other public sector hospitals and other health facilities and providers to the ISDN;
- Mobilizes available logistics and financial assistance in favor of the ISDN; and
- Provides technical inputs in the areas of capacity-building especially for service providers, enhancement of health facilities, operations of health systems, service standards, and other technical aspects of ISDN operations.

(C) Department of Social Welfare and Development-NCR

- Through its office and satellite centers and institutions, provides social welfare services for CICLs and victims of abuse and violence and other segment of adolescents and youth with special social needs.

(D) International Development Partners

- Extend technical and financial assistance and grants in the development and implementation of comprehensive adolescent health and wellness strategies in the city.

Section 5. Effectivity. This Agreement takes effect on _____.

IN WITNESS WHEREOF, ALL PARTIES HEREIN REPRESENTED undertake to affix their signatures:

ISDN Member	Position/Organization	Signature	Date
Hon. Marcelino Teodoro	City Mayor, Marikina City		
Hon. Jose Fabian Cadiz	Vice Mayor, Marikina City		
Dr. Alberto Herrera	CHO, Marikina City		
Dr. Emmanuel Bueno	Administrator, Amang Rodriquez Medical Center ABC President, SK Federation President,		
Dr. Ariel Valencia	Private Hospitals in Marikina		

ANNEX I

SAMPLE AHD PROGRAM RESULTS MATRIX

Overall AHD Goal: **To improve the total well-being of adolescents in the locality or to enable them to achieve their potentials and aspirations**

AHD Long-Term Goals:

- To reduce the proportion of adolescents (10-19) who have begun childbearing from 32% in 2018 to 20% in 2022
- To reduce the age-specific fertility rate (ASFR) of women aged 15-19 from 57 births/1,000 live births in 2018 to 35 births/1000 live births in 2022
- To reduce proportion of adolescents who are living-in from 5% in 2018 to 2% in 2022
- To improve completion rate in secondary level from 75% in SY 2017-2018 to 90% in SY 2022-2023
- To reduce drop-out rate at the secondary level from 15% in 2018 to 5% in 2022 (Or to reduce the number of out-of-school youth from 300 in 2018 to 50 in 2022)
- To reduce the proportion of adolescents who are stunted from 10% in 2018 to 5% in 2022
- To reduce the proportion of adolescents who are involved in crimes from 12% in 2018 to 5% in 2022
- To reduce youth (15-24) unemployment from 35% in 2018 to 10% in 2022

Expected Performance Indicators (in 2022)			
IMPACT	**OUTCOME**	**OUTPUT**	**INPUT**
• 20% of adolescents who have begun childbearing • ASFR of 25 births/1000 live births • 5% of adolescents in living-in arrangement	• 10% (from 25%) of adolescents who have ever experienced pre-marital sex • 75% of adolescents have used contraception during their pre-marital sex	• 75% of adolescents provided with ASRH information • 50% of adolescents provided with appropriate ASRH services • 50% of parents with adolescent children able to provide ASRH information to their adolescents	• All schools conducted ASRH communication strategies • All schools established their AHD teen centers • All MAPEH teachers trained on ASRH • All Officers of Parent-Teachers Associations (PTA) oriented on ASRH • All barangay officials oriented on ASRH • All barangays have established community-based AHD teen centers • All SK officials and members provided with ASRH information

Expected Performance Indicators (in 2022)			
IMPACT	**OUTCOME**	**OUTPUT**	**INPUT**
• 90% completion rate in secondary level • 5% drop-out rate at the secondary level • Less than 50 number of out-of-school youth	• 100% participation rate at secondary level	• 100% of OSYs enrolled in ALS • 100% of 4Ps families compliant to condition on education	• All barangays with high school • All barangays with ALS activities • 100% of indigent students enrolled in school-feeding program • 1:45 classroom to student (secondary) ratio • 1:45 teacher to student (secondary) ratio • Families of indigent students enrolled in 4Ps • ___ of students supported with scholarship programs • All students provided with appropriate ASRH information
• 90% completion rate in secondary level • 5% drop-out rate at the secondary level • Less than 50 number of out-of-school youth	• 100% participation rate at secondary level	• 100% of OSYs enrolled in ALS • 100% of 4Ps families compliant to condition on education 6	• All barangays with high school • All barangays with ALS activities • 100% of indigent students enrolled in school-feeding program • 1:45 classroom to student (secondary) ratio • 1:45 teacher to student (secondary) ratio • Families of indigent students enrolled in 4Ps • ___ of students supported with scholarship programs • All students provided with appropriate ASRH information
• 5% of adolescents who are stunted	• 100% of adolescents taking nutritious food • 25% of adolescents eating junk foods	• 100% of adolescents provided with appropriate information on proper nutrition • 100% of person preparing food at home provided with appropriate information in preparing healthy and nutritious food • 100% of adolescents provided with vitamin supplements	• All barangays with food and vitamin supplementation programs • All barangays with sports and recreation programs involving adolescents

POPCOM

Empowering Filipino Families

COMMISSION ON POPULATION AND DEVELOPMENT
Welfareville Compound, Acacia Lane, Mandaluyong City

(632) 531-7164 (632) 531-6805
(632) 533-5122
mainmail@popcom.gov.ph
www.popcom.gov.ph
fb.com/commissiononpopulationanddevelopment